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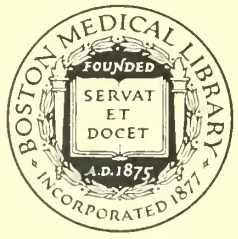

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PENNSYLVANIA MEDICINE

JULY 1969

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Warning: Althaugh generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiavascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potentiol risks.

Adverse Reactions: Rarely severe enaugh to require discontinuatian of therapy, unpleasont symptams with diethylpropian hydrachlaride have been reported to occur in relatively low incidence.

As is characteristic af sympathomimetic agents, it may occasianally cause *CNS effects* such as insamnia, nervousness, dizziness, anxiety, and jitteriness. in cantrast, CNS depressian has been reported. in a few epileptics an increase in canvulsive episades has been reparted.

Sympathomimetic *cardiavascular effects* reparted include anes such as tachycardia, precardial pain, arrhythmia, palpitation, and increased blaad pressure. One published report described T-wove changes in the ECG of a healthy yaung male after ingestion of diethylpropian hydrochlaride; this was an isalated experience, which has not been reparted by athers.

Allergic phenamena reparted include such canditians as rash, urticaria, ecchymosis, and erythema.

Gastraintestinal effects such as diarrhea, canstipatian, nausea, vamiting, ond abdominal discomfart have been reported.

Specific reparts on the hematapaietic system include twa each af bone marraw depressian, ogranulocytasis, and leukopenia.

A variety of miscellaneous adverse reactians have been reparted by physicians. These include complaints such as dry mauth, headache, dyspnea, menstrual upset, hair lass, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, In midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one haur befare meals. If desired, on additianal toblet may be given in midevening ta avercame night hunger. Use in children under 12 years af age is nat recammended.

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(diethylpropion hydrochloride)

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PENNSYLVANIA MEDICINE /medigram

JULY, 1969

PHYSICIANS EFFECTED BY "TRUTH IN LENDING" BILL

On July 1, 1969, when the truth in lending regulations of the Consumer Credit Protection Act become effective, they will cover doctors, dentists and hospitals, along with department stores and lending institutions, or any person or business which regularly extends or arranges for credit to individuals for personal, family, household or agricultural purposes. According to the Federal Reserve Board which wrote the truth in lending section of the Act, the information which must be provided to the user of credit is the finance charge in dollars and cents and the annual percentage rate. In the case of open end credit, where the charge is made on the unpaid balance, the finance charge is divided by the unpaid balance to obtain the rate for one month. This is multiplied by twelve to get the annual percentage rate which must appear on all statements, along with the unpaid balance, all current charges, any payments made during the billing period, and the finance charge in dollars and cents. Those extending credit are urged by the Federal Reserve Board to Consult Regulation Z of the Act in order to comply, thereby avoiding fines up to $5,000 or jail terms up to one year.

STATE DRUG CONTROL DIRECTOR APPOINTED

Deputy Secretary of Health for Drug Control Paul A. Rittelman has announced the appointment of Samuel Levine as Pennsylvania's director of the Division of Drug Control. Mr. Levine is former Federal Bureau of Narcotics district supervisor, and succeeds John A. Dattoli, M. D., who has been named director of the Division of Alcoholism Studies and Rehabilitation.

"MEDICAL ECONOMICS FOR THE PRIVATE PRACTITIONER" BRIEFING SET IN NEW YORK

A special one-day session on "Medical Economics for the Private Practitioner" has been scheduled by the American Management Association for July 18 at the Barbizon Plaza Hotel in New York City. The briefing will follow the AMA Convention to be held earlier the same week and is designed for the private medical practitioner who is seeking better ways to manage his finances and improve his economic security. Highlights of the meeting will include discussions of: Establishing a Professional Corporation, Group Practice, Investment Management Opportunities, Insurance--Determining the Optimum Amount of Coverage and Protection Against Malpractice and Negligence Suits.

HOUSE RESENTATION ASKED

Representatives of specialty organizations in the state at a meeting in PMS Headquarters voted to ask the State Society House of Delegates for specialty representation in the House. They suggested that each specialty with established Boards have one delegate in the House. They argued that delegates elected by county societies speak for the counties they represent and that the specialties thus have no direct, formal voice in the operation of the State Society. Their suggestion will reach the House via the PMS Board of Trustees. In addition, the group voted to remain in existence, if the PMS Board agrees, as an inter-specialty committee to improve liaison among themselves and with the State Society.

GERMANTOWN ACADEMY SLATES SPORTS MEDICINE SEMINAR

A two-day program providing a review of modern developments in sports medicine with particular emphasis on conditioning, mental and physical, and the prevention of injury has been scheduled for August 14 and 15 at Germantown Academy, Fort Washington, Pa. The two-day course is designed for progressive team physicians, nurses, athletic directors, administrators, trainers, and coaches for colleges and private, parochial and public schools, as well as for anyone else interested in sports medicine problems. Details of the event may be obtained from David G. Moyer, M. D., at the academy.

DRUG ABUSE CAMPAIGN PLANNED

The Pennsylvania Medical Society and the Pennsylvania Federation of Women's Clubs are embarked on a $20,000 effort in drug abuse education to start this fall. The campaign includes a year-long series of public service sound, color film announcements for television, the production of which is already underway. This marks the first time that the State Society has joined with other than a health-directed organization in a joint project. It resulted from talks between the Council on Public Service and federation officials.

STATE SURVEY PLANNED

The Community Health Research Group of Ohio State University has started a survey that includes collecting data from Pennsylvania physicians about drug therapy problems. The data will be used for problem-solving seminars and other instruction, officials of the group said.

MALARIA INCREASE REPORTED IN STATE

Malaria, a disease which as recently as 1962 was all but eliminated in Pennsylvania, has been showing steady increase in reported cases, according to I. F. Gratch, M. D., epidemiologist for the State Department of Health. The final summary of the department's division of communicable diseases showed 190 reported cases of malaria, all but four of them contracted in Viet Nam.

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■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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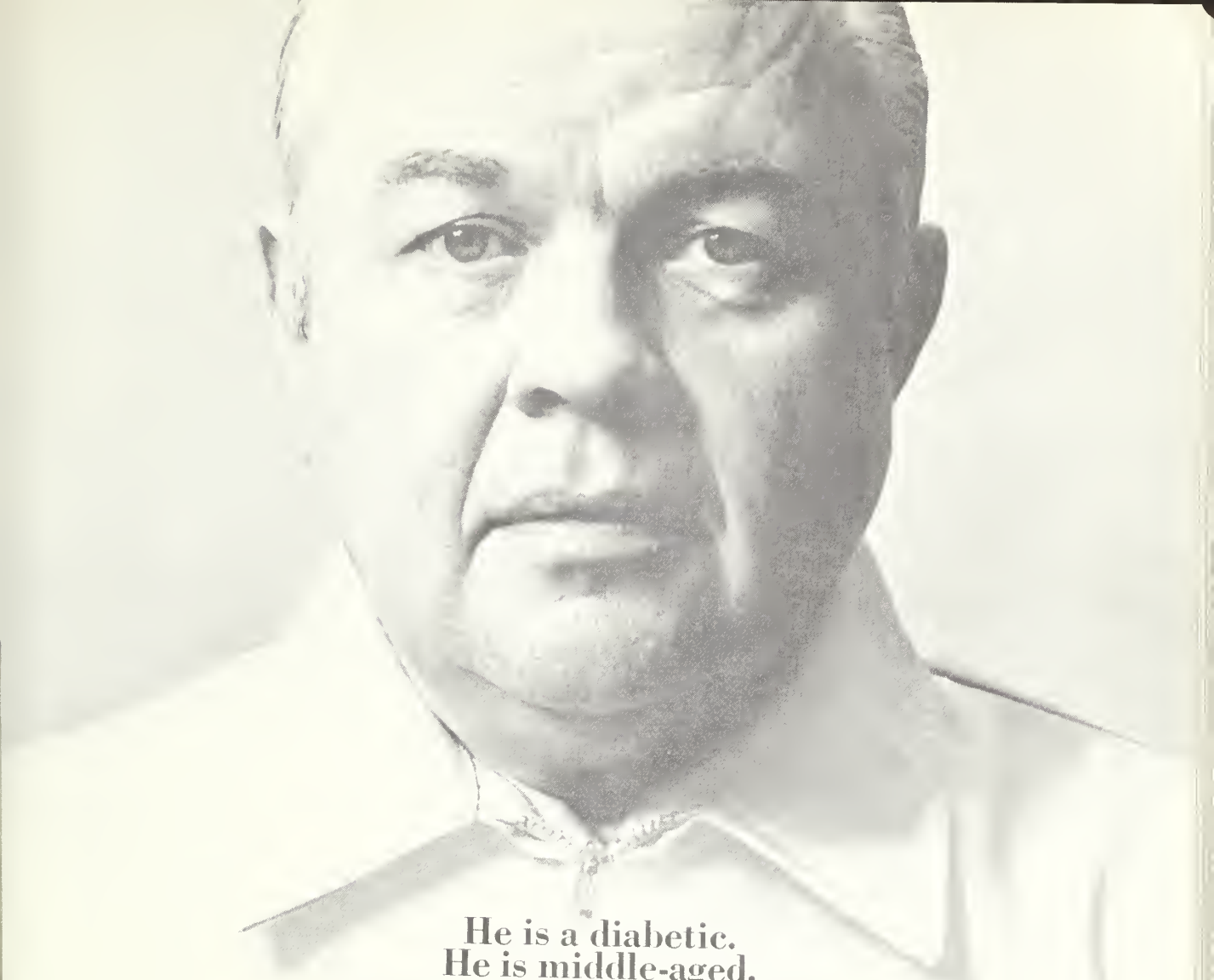

He is a diabetic.
He is middle-aged.
When he needs an antibiotic he may be a candidate for

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Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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100 mg phenylbutazone
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If it doesn't work in a week, forget it.

But don't forget that serious side effects can occur. Select patients carefully (particularly the elderly) and follow them closely in line with the drug's precautions, warnings and contraindications.

Check the prescribing information. It's summarized on the next page.

BU-6376

Butazolidin®alka

Geigy

Capsules
100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate

If it doesn't work in a week, forget it.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of the alka formulation are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. Patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angiitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

In selecting the appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response. (B)46-070-B

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Opening Doors Of Understanding

Our Men In Washington

Pennsylvania Doctors Visit Legislators; Briefed on Medical-Political Climate

With their hands extended, but not to ask favors, more than fifteen Pennsylvania physicians went to Washington last month to offer Commonwealth legislators a supporting arm to help solve the nation's problems, particularly on issues of health.

The June visit was a continuation of an annual trek to Capitol Hill by a Pennsylvania delegation of doctors to apprise themselves of current trends in governmental attitudes toward the health profession, to obtain a broader insight into the docket of proposed and current health legislative matters and to inform their Congressmen that they and most of their medical associates at home are frontline ready to assist when called upon.

That the government is exerting a more active interest in the cost and delivery of medical care is nothing new to the doctor. Just how far the government will extend its interests into a heretofore traditionally independent enterprise, how great an inroad will be made in the establishment of national standards and national programs in the practice of the healing art is the critical concern.

What Pennsylvania physicians did hear from their Congressmen during their two-day visit was a restating of the fact that the doctor, and he alone, is the keystone of influence in medical legislation.

The Pennsylvania entourage was one of numerous medical pilgrimages from various states to Washington, D.C. this year for the purpose of further devel-

AMA effectiveness through the years has done much to advance the cause of the art and science of medicine.

oping a better line of communication between the practitioner and the politician.

During their forty-eight-hour stay, Commonwealth doctors received a midday briefing on the current political scene by representatives of the AMA Washington office, conducted private visits with their Congressmen on the Hill, continued their political-medical discussions at a buffet dinner in the Rayburn House Office Building, and later held a breakfast post-mortem on fruitful meetings.

During the AMA briefing prior to meeting with Congressmen, the delegation learned that legislation generally was off to a slow start and that Congress on both sides had met very few hours this year. This lag was attributed, in part, to a change in the Administration and in top personnel in a number of agencies.

In the case of health legislation, the slow pace is due in part to the retirement of Senator Lister Hill, long-time chairman of the Senate Labor and Public Welfare Committee.

Senator Ralph Yarborough (D., Texas) replaced Hill and has been in the process of rebuilding the administrative staff of his committee. Yarborough has kept his position as chairman of the Health Subcommittee of the Labor and Public Welfare Committee, which has further delayed action.

However, the Hill-Burton Hospital Construction Act, which passed the House 351-0 recently, has been sent to the Senate for hearings.

Delegates learned that 80 per cent of all health legislation must be heard by the Labor and Public Welfare Committee of the Senate before reaching the full Senate for action. The other committee of importance in health bills in the Senate is the Finance Commit-

William J. Colley
AMA Washington Staff

Wayne W. Bradley
AMA Washington Staff

C. Darrell Coover, Director
AMA Department of Governmental Relations

Maintaining steady contact from home with elected representatives influences what happens to national legislation.

tee which provides the funding. On the House side, the committees of importance in health matters are the House Interstate and Foreign Commerce Committee and the Ways and Means Committee.

In discussing the status of health legislation, the AMA representatives re-emphasized that lateness could be expected but that some activity on the following pieces of legislation would be forthcoming: The Hill Burton Hospital Construction Act (passed House, awaiting Senate action); Medical Library Assistance Act (hearings begun in the Health Subcommittee of the House); and on extensions of Comprehensive Health Planning, Regional Medical Programs, Health Research Facilities Construction Act, Health Services Research and Development Amendments, Health Services for Migratory Agricultural Workers Amendments, Clean Air Act and Solid Waste Disposal Act.

The AMA Washington group also informed the Pennsylvania delegation of their eight-point proposed legislative program approved by the AMA Council on Legislative Activities.

In the proposal is a bill to amend the antitrust laws to provide that the refusal of non-profit blood banks and of hospitals and physicians to obtain blood, blood plasma or other tissue from other blood or tissue banks shall not be deemed to be acts in restraint of trade.

Another piece of legislation would create a national advisory commission to study medical devices to determine the need and extent for federal regulation, minimum performance standards for such devices and the method of determining medical value of devices. The commission is to report within three years.

There are bills to eliminate the re-

Harry R. Hinton
AMA Washington Staff

Paul R. M. Donelan
AMA Washington Staff

James W. Foristel
AMA Washington Staff

Robert J. Carroll, M.D., left, and Congressman Albert W. Johnson, in deep discussion.

Representative Joshua Eilberg, left, listens as Patrick B. Storey, M.D., makes a point.

George E. Farrar, Jr., M.D., PMS president, left, chats with Congressman Daniel J. Flood.

In the center photograph, James Robinson, M.D., left, holds the attention of Pennsylvania's senior senator, Hugh Scott. In the bottom picture, George W. Shaffer, M.D., left, and Congressman J. Irving Whalley meet.

certification requirement for general inpatient hospital services under Medicare; to remove limitations for psychiatric care under Title 18 and Title 19 so that mental conditions are treated as any other illness; and to permit direct billing of all Title 19 recipients and thereby allow a cash recipient to have the same responsibilities as any other patient; to enable beneficiaries under Title 19 in Puerto Rico, Virgin Islands and Guam to have free choice of providers of services; and a bill to provide veterans an option to receive hospital care in facilities other than VA facilities, thus allowing them to receive care in their own communities and reducing the need for new VA facilities.

A bill of particular significance to doctors is one that would amend the Military Selective Service Act of 1967 as it pertains to selective service calls for physicians, and to provide for allocation of health personnel among the armed forces, government and the civilian community. The allocations would be made by a National Commission on Health Resources and Medical Manpower, composed of fifteen representatives from the health fields, including physicians in the private practice of medicine. The president would have to be guided by the commission's recommendation with respect to the selection of physicians, dentists and other health personnel.

The American Medical Association maintains a Washington, D.C. office whose staff includes four active lobbyists who contact the 535 members of Congress. Although the AMA lobby is small, it has proved its effectiveness in aiding, through the years, the passage of many bills which have advanced the art and science of medicine.

Unlike many lobbyists, the AMA only occasionally sponsors legislation. Most often, the Association utilizes its Washington office to follow legislative proposals of medical interest which are introduced in the Congress, and to provide the federal government with a means by which it may utilize the counsel and assistance of the AMA on matters of the nation's health.

AMA officials pointed out to Pennsylvania physicians that people who visit their Congressmen in Washington and who maintain regular contact by mail or phone, will also influence what happens to national legislation concerning medicine as well as legislation at the state level. However, the political activity must be aggressive and must have continuity. Once the rapport

has been established with the Washington representatives, positive results will ensue.

It was pointed out that the AMA, because of its national level of interest, is limited in the degree of influence it can exert on Congress. The legislators are interested, most of all, in voter following from their home states. If the voters are content, the Congressmen will stay in office—and that is the real meat of the matter.

In his community, the physician is a voter leader and the politician is aware of that. However, the doctor must let his Congressman know that he is an intelligent constituent, that he is vitally interested in the political issues of the day and that he, the physician, intends to be a spokesman on these issues. Not only must the physician express his position by offering advice to his representatives, he must also place demands on them for specific legislative action—pointing out to the Congressmen why the action is beneficial both in the practice of medicine and to their own political careers.

The physician delegation from Pennsylvania agreed that the Washington visit was beneficial mutually to the doctor and his legislative representative.

At a debriefing held at the close of the visit several positive suggestions for follow-up contact and for improving the Congressional visit were made.

The fact that Congressmen generally received their physician visitors with cordiality and participated in the delegation activities with substantial representation shows that they are interested in the opinions of their constituents and of organized medicine on health issues.

Several physician delegates agreed that a greater effort should be made to see that every county has a representative at the next scheduled visit.

In pursuit of influencing major health legislation imminent for Congressional action, a recommendation was made at the debriefing that individual physicians should take it upon themselves to make a trip to visit their representatives in Washington to apprise them of their interest in the bills. Lobbyists do as much as they are able the Pennsylvania delegation agreed, but support must come from the voters who send representatives to Congress.

During the nearly three-hour debriefing, the members of the Pennsylvania medical delegation agreed unanimously that immediate steps must be taken, both individually and through

In the top photograph, Daniel Pisano, M.D., left, talks with Eugene S. Cowen, Senator Scott's administrative assistant. Mrs. George E. Farrar, left, in the second picture, makes a point with Senator Richard S. Schweiker. The five men in discussion in the middle photograph are, left to right, Paul S. Friedman, M.D., Dr. Farrar, Congressmen John H. Dent and John

P. Saylor, and John B. Lovette, M.D. In the second picture from the bottom, Representatives Thomas E. Morgan, left, and John H. Dent, center, and Ralph J. Stalter, M.D., right, are conferring. William R. Hunt, bottom left, and Congressman William S. Moorhead seem to enjoy the opportunity to exchange ideas.

the capable offices of PaMPAC, to establish a firm, open communication line between themselves and their representatives; and that these avenues must be kept open by a vigorous and untiring program to provide legislators with up-to-the-minute reports on the sentiments and desires of their constituents. Only with such support can the Congressmen act judiciously and intelligently in favor of the medical profession.

Representing the medical profession in the Commonwealth were: Robert F. Beckley, M.D., George E. Farrar, Jr., M.D., Paul S. Friedman, M.D., Richard L. Huber, M.D., William R. Hunt, M.D., Charles J. H. Kraft, M.D., George W. Shaffer, M.D., Patrick B. Storey, M.D., John B. Lovette, M.D., Marshall M. Johnson, Jr., M.D., Daniel Pisano, M.D., James Robinson, M.D., William A. Barrett, M.D., Ralph J. Stalter, M.D., Robert J. Carroll, M.D., and Donald Harrop, M.D.

Among the Congressmen receiving the Pennsylvania delegation were: William A. Barrett (D—1st Dist.), Edward G. Biester, Jr. (R—8th Dist.), Lawrence Coughlin (R—13th Dist.), John H. Dent (D—21st Dist.), Joshua Eilberg (D—4th Dist.), Edwin D. Eshleman (R—16th Dist.), Daniel J. Flood (D—11th Dist.), Albert W. Johnson (R—23rd Dist.), Joseph M. McDade (R—10th Dist.), William S. Moorhead (D—14th Dist.), Thomas E. Morgan (D—26th Dist.), John P. Saylor (R—22nd Dist.), Herman T. Schneebeli (R—17th Dist.), G. Robert Watkins (R—9th Dist.), J. Irving Whalley (R—21th Dist.), Gus Yatron (D—6th Dist.) and Republican Senators Hugh Scott and Richard S. Schweiker.

William A. Barrett, M.D., *a member of the Pennsylvania group, makes a point at the debriefing which marked the end of the Washington visit.*

Other members of the Pennsylvania delegation included Mr. Chad P. Combs, AMA public relations field representative in Pennsylvania; Mr. John F. Rineman, PMS assistant executive secretary; Mr. Robert H. Craig, Jr., executive assistant for the Council on Governmental Relations and Mr. Jerry Rothenberger, executive director, Pennsylvania Medical Political Action Committee.

Washington Profile—*we're here to listen, to counsel and to act.*

Governments, Like Clocks, Go From The Motion Men Give Them; And As Governments Are Made And Moved By Men, So By Them They Are Ruined, Too. Where-Fore Governments Rather Depend Upon Men Than Upon Governments
Preface To Pennsylvania's Frame Of Government
POLITICAL DIFFERENCE IS GOOD DEMOCRACY. IT IS POLITICAL INDIFFERENCE WHICH IS OUR DANGER.
BE ACTIVE IN YOUR STATE AND YOUR NATION'S GOVERNMENT AFFAIRS. WRITE TODAY—
PENNSYLVANIA MEDICAL POLITICAL ACTION COMMITTEE
P. O. BOX 295, LEMOYNE, PA. 17043

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

Pertofrane®
desipramine hydrochloride
In depression...
when words are not enough

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

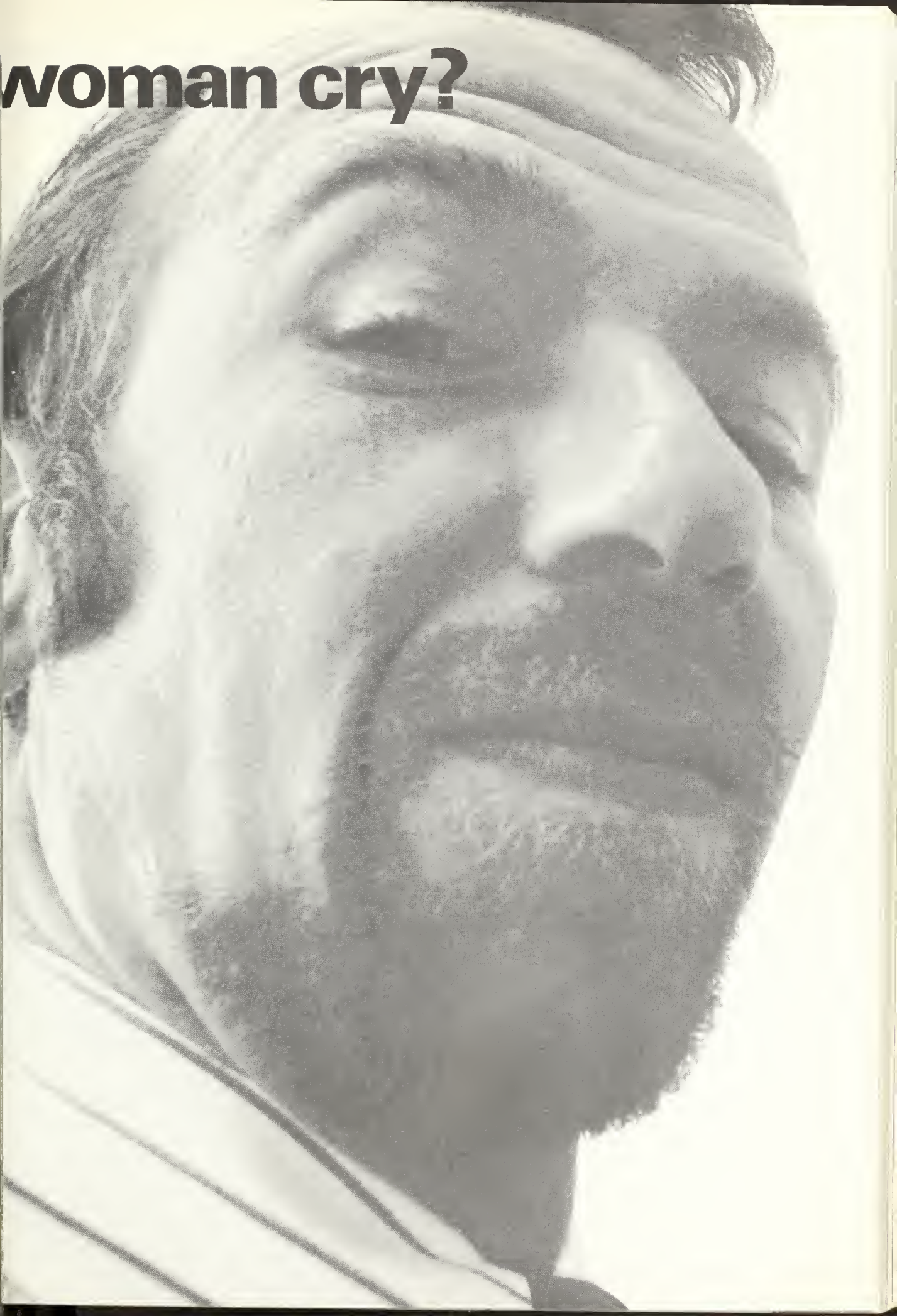
Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M A O I class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M A O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

woman cry?



22nd Annual STATE DINNER

• *Program* •

Reception
Dinner
Dancing and Entertainment

Installation of Carl B. Lechner, M. D., as the 120th President of the Pennsylvania Medical Society

Presentation of Past President's Medallion to George E. Farrar, Jr., M.D., 119th President

Tribute to Mr. Lester H. Perry, Retiring Executive Director, Pennsylvania Medical Society [1934-1969]

Presentation of the State Benjamin Rush Awards

FRIDAY EVENING
OCTOBER 10, 1969
PHILADELPHIA MARRIOT
MOTOR HOTEL

The burdened heart...

The burdened heart, psychic tension, and adjunctive therapy with Valium® (diazepam):

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Artist's conception schematically showing varying ischemic ventricular muscle tissue.

To help lift psychic tension from the already burdened heart

When the cardiac patient shows signs of panic-like reactions following initial diagnosis—a daily regimen of 10-mg Valium (diazepam) tablets *t.i.d.* or *q.i.d.* can help control *severe* psychic tension, anxiety, apprehension and agitation. For *less severe* emotional stress, the 5-mg tablet usually provides the desired calming effect.

When the cardiac patient's outlook impedes convalescence—Valium, as it relieves psychic tension, can help the patient regain a realistic perspective... help him deal more rationally with convalescence by countering excessively anxious attitudes towards the future.

When the cardiac patient can't adjust emotionally to post-recovery limitations—Valium, through its prompt and pronounced calming action on psychic tension, may help avoid exacerbation or aggravation of cardiac symptoms.

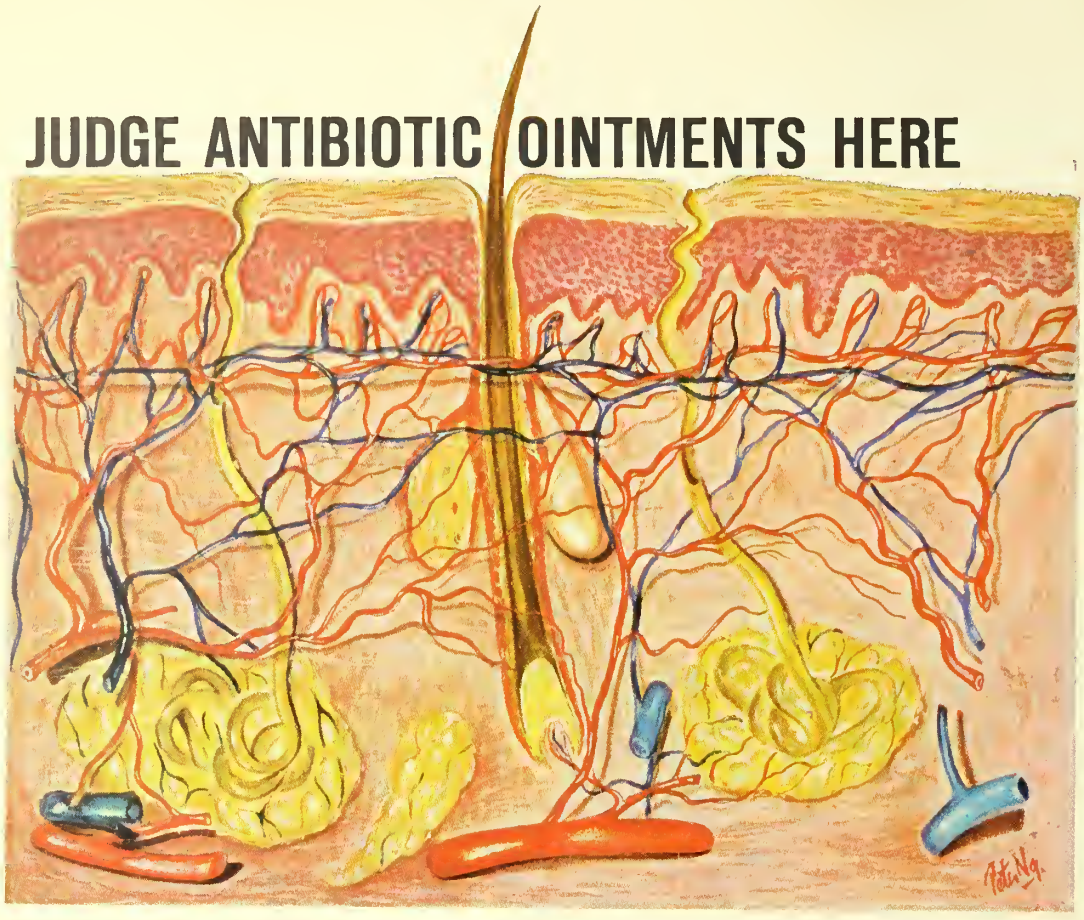
On proper maintenance dosage, Valium seldom dulls the senses or interferes with functioning.

Should anxiety-induced insomnia be a problem—an *h.s.* dose added to the *t.i.d.* schedule usually helps permit a night of restful sleep.

Valium®
(diazepam)

2-mg, 5-mg and 10-mg tablets
t.i.d.* and *h.s.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

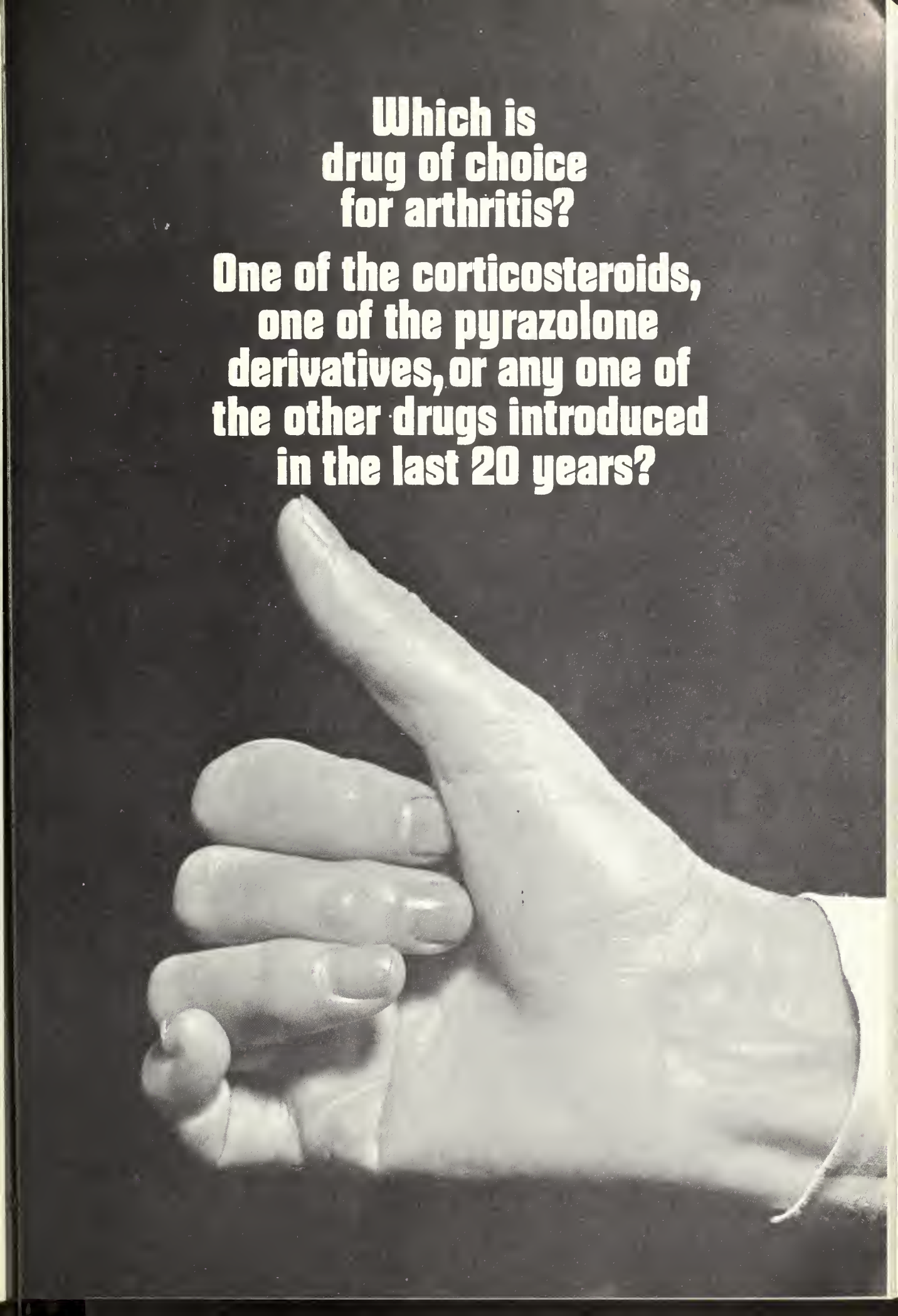
brand

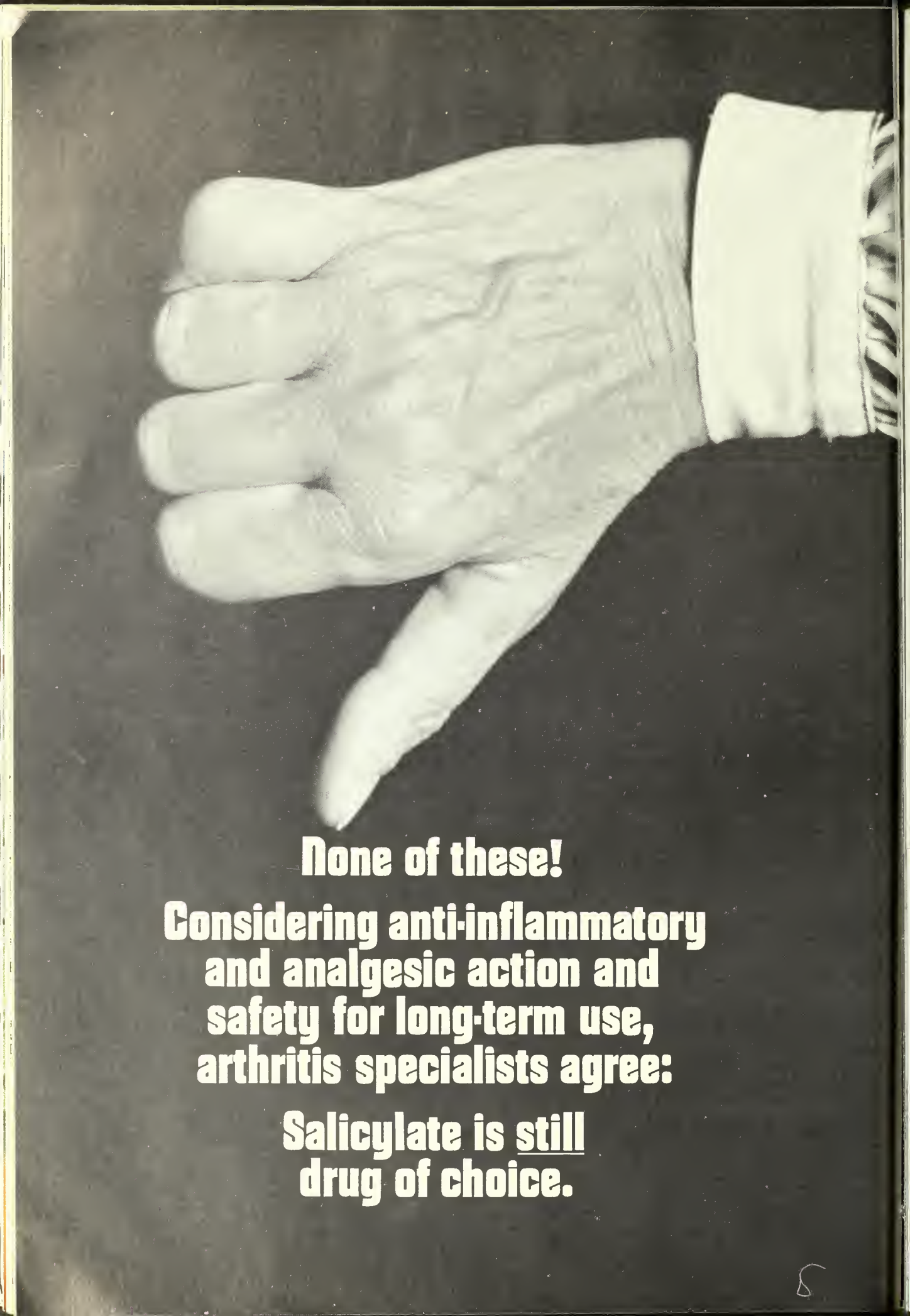
POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Which is drug of choice for arthritis?

One of the corticosteroids, one of the pyrazolone derivatives, or any one of the other drugs introduced in the last 20 years?




None of these!
Considering anti-inflammatory and analgesic action and safety for long-term use, arthritis specialists agree:
Salicylate is still drug of choice.

Here's what they say:

"Various derivatives of salicylic acid have, for a long time constituted the most reliable analgesic medicines for relief of rheumatic pain . . . Failure to obtain good analgesia from salicylates is often due to the use of inadequate amounts or to improper timing of doses."
Freyberg, R.H.: M. Times 95:740 (July) 1967.

"The anti-inflammatory property of salicylate (aspirin or sodium salicylate) is the backbone of antirheumatic management . . . Only if a program of adequate nutrition, rest, local counter-irritants and salicylates fails after a substantial trial (viz; 3-6 mo.) should more potentially hazardous medication be employed."
The Merck Manual, 11 ed. p. 953, 1966.

"The analgesic property of salicylates is undoubted . . . The question whether or not salicylates are anti-inflammatory in subjects with RA has been answered in the affirmative."
Arthritis & Rheumatism 9:205, (Apr.) 1966.

"All evidence indicates that conservative management offers a long-term prognosis at least no worse than that of more spectacular methods. Since none of these latter measures are curative, and because their administration is often accompanied by undesirable side effects, a conservative approach is the method of choice . . . Salicylates—Acetylsalicylic acid and sodium salicylate are the analgesic drugs of choice."
Engleman, E. P.: in Current Diagnosis and Treatment, p. 432, 1965.

". . . the salicylates are the most useful drugs in the treatment of rheumatoid arthritis and, in a considerable proportion of patients . . . is the only drug needed."
Primer on the Rheumatic Diseases, J.A.M.A., 190:127 (Oct. 12) 1964.

"Therefore, drugs or any therapy which is to be used must be chosen on the basis of the long-term therapy and for their safety . . . The best medication for the pains are salicylates."
Smith, R.T.: Sc., 15:75 (Jan.) 1964.

"Salicylates, however, remain the drugs of first choice, and research on salicylates has improved their formulation and effectiveness."
Today's Drugs, Brit. M.J., 2:1317 (Nov.) 1963.

"I want to stress the use of salicylates throughout all stages of the disease. Aspirin or sodium salicylate is most commonly used in a dosage of 2 tablets (0.6 gm, 10 gr) four times daily."
Smyth, C.J.: Postgrad. Med. 44:1 (July) 1968.

Pabalate®

Each enteric-coated tablet contains:
sodium salicylate, 0.3 Gm.,
sodium aminobenzoate, 0.3 Gm.,
ascorbic acid, 50 mg.

a salicylate plus

Indications: For control of pain and inflammation associated with rheumatic affections such as rheumatoid arthritis, fibrositis, acute rheumatic fever, gout, osteoarthritis, etc.

Contraindications: Hypersensitivity to any of the ingredients.

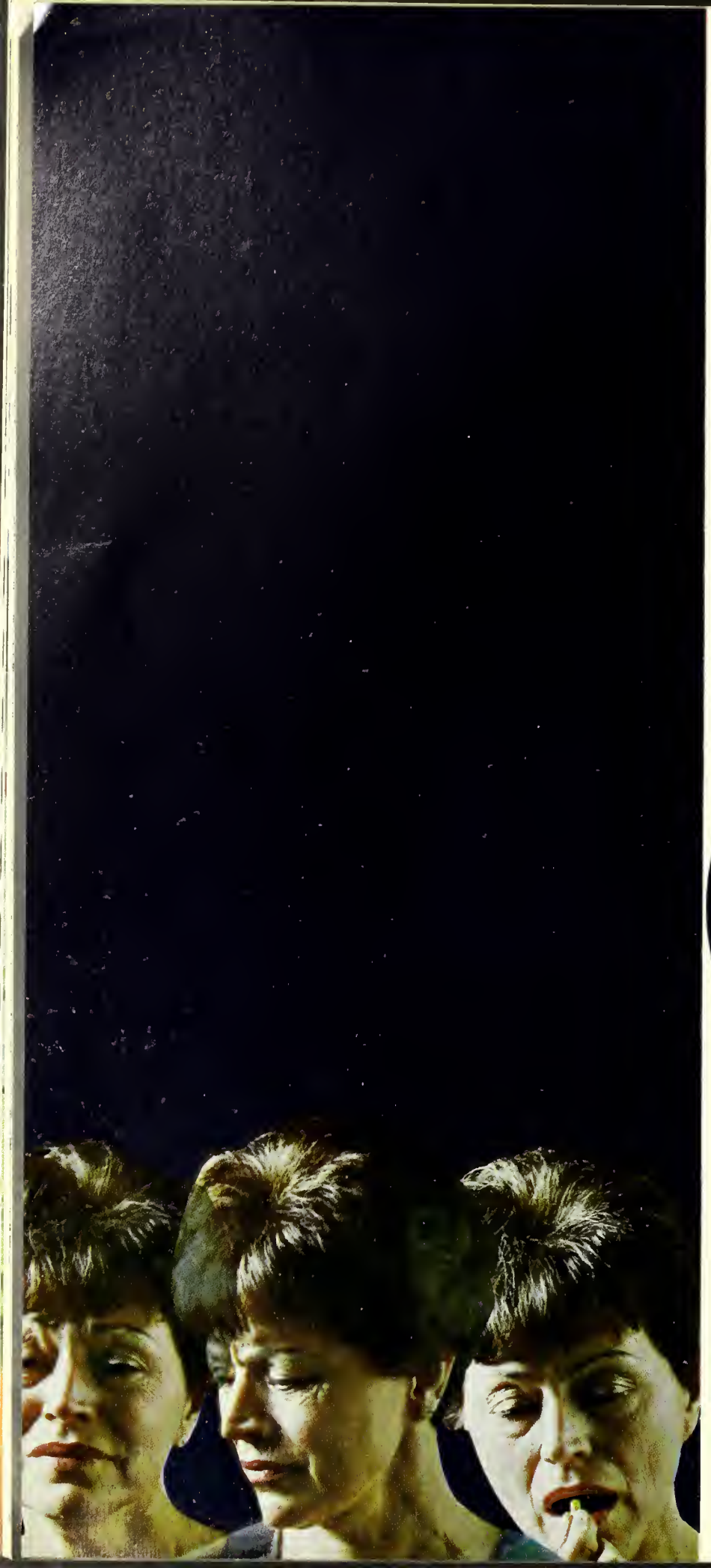
Precautions: When administered concurrently with sulfonamides, aminobenzoic acid inhibits the bacteriostatic action of the latter. Hypoprothrombinemia has been observed during prolonged and intensive therapy with salicylates. If patients receiving such dosages are to undergo surgery, the prothrombin time should be performed.

Side Effects: Nausea and gastrointestinal upset, fine rash with or without pruritus, and urticaria. The occasional occurrence of mild salicylism may require adjustment in dosage.

Dosage: The average adult dose is 2 tablets 4 times daily. The physician may increase dose as required.

Availabie in bottles of 100 and 500. See package insert for further details.

A.H. Robins Company,
Richmond, Va. 23220 A·H·ROBINS



THE RESPONSI GAP

Symptom reduction often begins within the first week with AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

All antidepressants take time to work. With Aventyl HCl, patients who will respond often begin to receive symptomatic relief within the first week of therapy. They may report sounder sleep, better appetite, increased interest, or other noticeable improvement in mood or activity.

In a study of two tricyclic drugs, "nortriptyline was associated with a more rapid symptom reduction during the first three weeks of treatment."* However, the author also reported that although some differences in response existed after three weeks, "they were no longer significant by the sixth week of treatment."* *Of course, maximum improvement with Aventyl HCl, as with other antidepressants, may require longer therapy, particularly in severe depressive illnesses.*

Aventyl HCl may help shorten the response gap . . . provides measurable symptomatic relief your patients often notice and appreciate.

*Mendels, J.: Comparative Trial of Nortriptyline and Amitriptyline in 100 Depressed Patients, Amer. J. Psychiat., *124*:59 (Feb. Supp.), 1968.

10 mg.† 25 mg.† 10 mg.† per 5 cc.

†base equivalent

AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

Lilly

See next page for prescribing information.

900816

AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two weeks after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl HCl under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Patients receiving a tricyclic antidepressant (e.g., nortriptyline) may respond poorly to hypotensive agents such as guanethidine.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily
10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg. — Ages seven to twelve, 1 Pulvule one to three times daily
10 mg.—Ages three to six, 1 Pulvule one to three times daily
Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily
Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500. [081668A]

Lilly

Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

900816

PMS, Specialty Groups Meet

Specialty organization *representatives met with officials of the Pennsylvania Medical Society last month in an effort to establish a closer liaison between the major medical groups in the Commonwealth. George E. Farrar, Jr., M.D., PMS president, commented on the direction the State Society might move in relation to the specialty organizations. David S. Masland, M.D., vice chairman of the PMS Board of Trustees, welcomed the specialty representatives on behalf of the Board and expressed the Board's interest in establishing a stronger rapport. The day-long meeting centered around discussion of the role of specialty societies in organized medicine, the needs of the Pennsylvania Medical Society and of the specialty societies, representation of specialty societies in the PMS House of Delegates and the need for a committee within the structure of the State Society which would be composed of representatives of specialty organizations. More than twenty specialty organizations were represented at the meeting attended by ten PMS officials and staff personnel.*

State Interest Intensifies

Ad Hoc Malpractice Committee Appointed

Pennsylvania Insurance Commissioner David O. Maxwell announced today the appointment of a fifteen-man Ad Hoc Committee of medical, legal and insurance representatives for the purpose of working toward long range solutions of the medical malpractice insurance problem.

"No one can question the absolute necessity to the practicing physician or dentist of adequate malpractice insurance," Maxwell said. "In fact, it is difficult to imagine how a responsible member of the medical profession could practice without this important coverage."

The commissioner pointed out that the existence of a malpractice market crisis in Pennsylvania, particularly in Philadelphia and the surrounding counties, was confirmed by testimony secured at a hearing on this subject held by the department on April 2, 1969.

The new committee's chairman is A. John Smither, chief deputy insurance commissioner who will be assisted by Richard W. Simpson, assistant director of the department's bureau of regulation of rates and policies. Other members appointed by Commissioner Maxwell and the organizations which they will represent, include:

Robert P. Dutlinger, M.D., Harrisburg, Pennsylvania Medical Society; Alfred A. Grilli, D.O., Pittsburgh, Pennsylvania Osteopathic Association; Richard S. Kaplan, M.D., Philadelphia, Pennsylvania Orthopeadic Society; Ephraim S. Siker, M.D., Pittsburgh, Pennsylvania Society of Anesthesiologists; Francis J. Sweeney, Jr., M.D., Philadelphia, The Hospital Association of Pennsylvania; R. Robert Tyson, M.D., Philadelphia, Philadelphia County Medical Society; Ray Cobaugh, Harrisburg, Pennsylvania Dental Association; David R. Lowe, Jenkintown, The Medical Protective Company; Edward H. Morgan, Hartford, Conn., Aetna Life & Casualty Insurance Company; J. D. Craddock, Philadelphia Insurance Company of North America; F. X. Lusch, Philadelphia, Mather & Company; Homer W. King, Esq., Pittsburgh Bar Association and Arnold M. Kessler, Esq., Philadelphia, Philadelphia Bar Association.

"Shall I order Maalox?"

"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

ROHRER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

Yes! Medi Card guarantees you 94% payment within 10 days — without recourse.

This unique professional credit card exclusively for health services helps you get out of the credit and collection business . . . frees your capital for investment. You merely mail your draft to Medi Card on simple, easy-to-use forms supplied at no cost. Medi Card pays you promptly, less only a 6% service fee. There is no commitment on your part, nothing to join, no directory or listing of any kind. *Your patients benefit, in other ways, too!* Medi Card makes from $100 to $5000 available to patient-members exclusively for professional health services . . . lets them take up to 24 months to pay. As an additional benefit, Medi Card offers a round-the-clock computerized emergency medical information service for cardholders.

94 IS NORMAL with Medi Card
Medi Card guarantees you payment within 10 days . . . without recourse.

EXCLUSIVELY FOR THE POST-PAYMENT OF THESE UNIVERSAL HEALTH SERVICES:
☐ MEDICAL ☐ DENTAL ☐ HOSPITAL ☐ NURSING HOME ☐ PHARMACY
AND OTHER BONA FIDE HEALTH SERVICE CHARGES

MEDI CARD, INC.
P.O. Box 650
Bala Cynwyd, Pa. 19004

Medi Card answers some frequently asked questions.

Q. Does Medi Card conflict with pre-paid health plans?

A. No. On the contrary, Medi Card both complements and supplements Blue Cross/Blue Shield and other pre-paid insurance programs; that portion which your patient would normally pay by cash may be charged to Medi Card.

Q. Can Medi Card now take over my patients' accounts receivable?

A. Medi Card cannot take over your patients' accounts receivable at this time but will process all patient applications received from you without charge.

Q. Do you make an individual credit check on each one of my patients?

A. Every application for Medi Card receives a thorough credit check before any card is issued.

Q. Are patient application forms readily available?

A. Yes. Applications to Medi Card are included in your professional kit and additional ones are available without charge.

Q. What methods will you use for collecting delinquent accounts? How does my state professional society feel about this?

A. Delinquent accounts will be automatically transferred to the same collection agency currently used by your local professional society.

Q. How does the AMA, the ADA, the AHA and my state professional society feel about Medi Card?

A. All terms of the Medi Card program have been presented and thoroughly discussed with these professional associations. They have informed us that they neither approve nor disapprove of Medi Card, they have no objections to our presenting the program to the individual members of the professions.

Q. Do I have to join, or become a member of Medi Card? Is there anything to pay in order to participate in the Medi Card program?

A. There is nothing to pay. You neither join Medi Card nor make any agreement with Medi Card. You merely honor the credit card upon its presentation, and are required to sign a statement accompanying the patient's first draft acknowledging your understanding of the program and Medi Card's 6% service charge.

Q. Can a card holder's Medi Card be used by various members of the family?

A. Medi Card may be used by any member of the family providing the card holder signs the Medi Card draft.

Q. What about Medi Card's financial responsibility?

A. Medi Card, a publicly held corporation, is associated in this program with Financial Services, Inc., a wholly owned subsidiary of the Diners Club.

Q. How much paperwork is involved?

A. The Medi Card draft is the simplest form ever devised for the payment of professional fees and services. Only two lines of the draft have been allotted for briefly outlining treatment. It is as fast as writing a personal check.

Q. Is there recourse to me in the event the patient does not pay Medi Card?

A. There is no recourse whatsoever. All the collection responsibility lies with Medi Card thus freeing you to maintain a professional relationship with your patient.

Q. Under what conditions will Medi Card refuse to pay a draft?

A. (1) Where the charge is incurred after the expiration date shown on the card. (2) Failure to fill out and mail processing card to us before, or along with, first draft.

Q. How much of my bill will Medi Card pay?

A. Medi Card will pay you up to the amount of credit shown on the face of the card, less the service charge.

Q. How does Medi Card protect the cardholder?

A. (1) Medi Card protects the cardholder by providing funds for professional services in amounts from $100 to $5,000 when they are needed. (2) Medi Card further protects the cardholder and his family by providing a 24-hour nationwide emergency medical information service making personal medical information available immediately through the use of a Medi Card toll-free telephone credit call. (3) In addition, this service provides all necessary professional payment information to the caller.

Q. How will I know each individual patient's Credit Limit?

A. Each patient's Credit Limit is clearly shown on the face of his Medi Card.

Q. Will you publish a list of professional participants?

A. No. Medi Card will not publish such a list because professional participants are not members of Medi Card.

What must I do to join Medi Card?

You do not join Medi Card so there is nothing to do — no membership forms or questionnaires to fill out. Medi Card provides you with a professional kit that comes without cost. Reorders of Medi Card drafts are also available free.

What is included in my professional Medi Card kit?

Your kit contains complete information and instructions on how Medi Card works, 100 drafts, a plaque stating you accept Medi Card and 200 application forms.

If my patient elects to use the extended payment plan, what are the service charges?

If a cardholder pays his Medi Card charge in full within 25 days, there is no service charge. If he elects to use the extended payment plan, Medi Card charges him 1½% per month on the unpaid balance, (or less, according to state legal rate). He may pay his balance at any time, during the extended payment period.

SEND FOR FREE KIT containing a supply of draft forms and complete details about Medi Card and how it helps both you and your patients. Use the handy pre-paid, pre-addressed card below, or write to Medi Card:

MEDI CARD, INC.
P.O. Box 650
Bala Cynwyd, Pa. 19004

Gentlemen: I have not received my Medi Card kit. Please send one as soon as possible to:

ATTENTION: _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____

SEND FOR FREE KIT
containing a supply of draft forms and complete details about Medi Card and how it helps both you and your patients. Use the handy pre-paid pre-addressed card below, or write to Medi Card:

MEDI CARD, INC.
P.O. Box 650
Bala Cynwyd, Pa. 19004

FIRST CLASS
PERMIT NO. 354
PHILA., PA.

BUSINESS REPLY MAIL
NO POSTAGE STAMP NECESSARY IF MAILED IN THE UNITED STATES

Postage Will Be Paid By

MEDI CARD INC.
P.O. BOX 650
BALA CYNWYD, PA. 19004

PMS Endorses SAMA Preceptor Program

The PMS Board of Trustees and Councilors has endorsed the program of the Student American Medical Association to expose medical students, under preceptors, to the actual practice of medicine in the rural areas of the Appalachian Region, which includes a portion of Pennsylvania. The State Society has offered assistance in locating suitable preceptors to work with the 100 medical students and twenty student nurses who have been accepted to work in the program.

George E. Farrar, Jr., M.D., PMS president, has urged all Pennsylvania doctors interested in becoming preceptors to cooperate with the effort. The program will begin in late June and run for nine weeks.

The Student American Medical Association will operate the program for the following purposes: To create an awareness of rural health needs and opportunities; to provide the student with an opportunity to identify with the rural practitioner of health care; to give physicians and other health care workers an appreciation and sympathy for the needs and goals of today's responsible activist students; and to provide, on a limited basis, for medical and nursing students to share in direct health service under supervision.

The medical students participating in the program come from all parts of the country. The nursing students are all in baccalaureate programs and most have completed their third year of study. Most of the medical students have completed at least two years of medical school.

Placement of students in the program, which begins with orientation in Morgantown, W. Va., June 21-23, will be in a variety of health care settings, according, as much as possible to the individual student's preference for locale and type of assignment.

Preceptors will be responsible for: showing the student his medical practice through daily sharing of office hours, hospital rounds and house calls; explaining to the student the resources available to provide health care in the rural setting and assisting the student to pursue his own individual interests, through independent reading, conducting a health survey, or studying a particular health care problem or resource which interests him.

Preceptors also are asked to find suitable housing for the students. Students will receive a stipend of $700 for the program in those instances where room and board are provided, and $900 where room and board are not provided. The Student American Medical Association has received a grant from the Appalachian Regional Commission to fund the program, which will end with an evaluation program and debriefing in Morgantown, August 22-24.

PMS Develops, Revises Public Service Pamphlets

A number of pamphlets and booklets have been developed or revised and reprinted by the PMS Council on Public Service.

Included in the listing are the revised "Services and Functions" booklet, the revised booklet "Welcome to Organized Medicine," various membership flyers, an abbreviated description of the state society for the public, a poison prevention leaflet, a revised Service Manual and a booklet on drug abuse entitled "The Crutch That Cripples."

With the current focus on drug abuse, nearly 10,000 copies of the latter publication have been distributed throughout the state.

The AMA, apparently in response to appeals from organizations throughout the country, has reduced prices on many of its health education leaflets which should enable the Society to reverse the decreased pamphlet distribution forced last year by increased costs.

Anatomical Gift Act Passes House By Slim Margin

The Pennyslvania House of Representatives has passed House Bill No. 2, the Uniform Anatomical Gifts Act, despite attempts by the Pennsylvania Funeral Directors Association to strip the bill of its purpose with crippling amendments. In a close vote of ninety-nine to ninety-two, with ten members not voting, the amendments were defeated.

The roll call on the bill revealed that Republicans gave only twenty-nine votes to defeat the crippling amendments, while Democrats provided the seventy votes which kept the measure intact. The final vote on the bill in the Democrat-controlled House of Representatives was 156 to 35, with ten members not voting.

The bill has moved to the Senate, where it has been referred to the Committee on Public Health and Welfare.

Library Confab Planned

The PMS Council on Education and Science is planning to sponsor a statewide, one-day conference entitled "The Hospital Library" for librarians, physicians, hospital administrators, nurses training school officials and research personnel.

To be scheduled in the near future, the meeting will feature discussions on all aspects of the economics and operation of hospital libraries, including the means of tying into the Regional Library Network.

Automated Abstracts Offered By Excerpta Medical

Excerpta Medica Foundation, a non-profit international organization founded in 1946 to abstract the medical literature of the world, announces that it has now developed a completed automated system of processing, storage and retrieval of the abstracts, prepared by its editors, of the world's biomedical literature.

newsfronts

Tick For Tat

It won't bring you anything in return except appreciation, but if you find a tick and mail it to the State Health Department, their entomologists will be most grateful.

According to William Wills, director of the department's Office of Research and Demonstration Projects, his people need several hundred live ticks for testing the efficiency of various insectide preparations. Some have been sent in by Health Department field personnel, but completion of the testing program is going to require "contributions" from outdoorsmen and others who would like to assist.

Wills said that ticks can be mailed satisfactorily in a small medicine bottle or any other small container.

Since some ticks are infected with germs that can cause Rocky Mountain spotted fever in humans, Wills warned that ticks should be handled only with tweezers or with a piece of a plastic bag. He also suggested that after a person removes a tick he should apply antiseptic to the bite mark and wash his hands with soap and water.

Wills said that ticks should be sent to the State Health Department Entomology Laboratory, Box 90, Harrisburg 17120.

PAMA Officers Installed

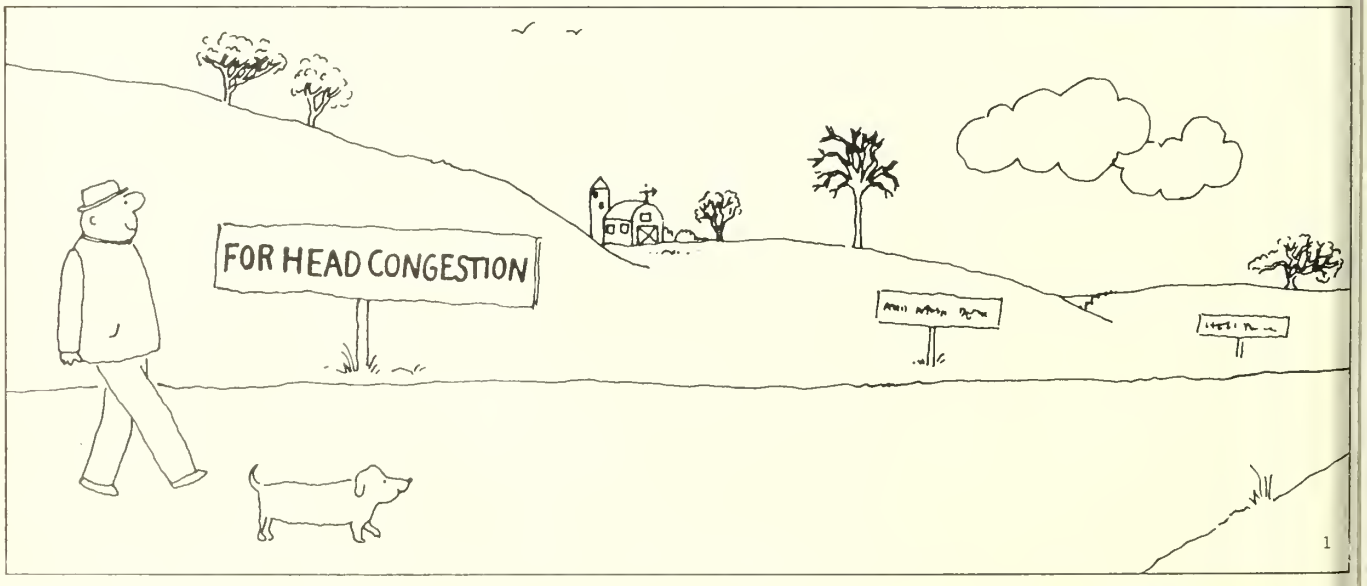
Installation of PAMA Officers—*George E. Farrar, Jr., M.D., PMS president, installs 1969-70 officers of Pennsylvania Association of Medical Assistants during organization's 12th Annual Convention in Philadelphia, May 16, 17, and 18. Officers are (l. to r.): Kathleen M. Rotoli, Philadelphia, Treasurer; Mrs. Maxine Apple, Altoona, Recording Secretary; Miss Jane McNulty, Dunmore, President-Elect; Mrs. Theresa Carter, Pottsville, Vice President; Miss Geraldine Shunkwiler, Paoli, President.*

Hospital Assn. President Elected

Edwin L. Taylor, of Narberth, Pa., was elected president-elect of the Hospital Association of Pennsylvania (HAP) recently at the HAP annual meeting in Atlantic City. Mr. Taylor, who is executive director of the Graduate Hospital of the University of Pennsylvania (19th & Lombard Streets, Philadelphia), will become HAP president in May 1970. He has been vice president of the association during the past year.

Sister M. Ferdinand Clark, Ed.D., administrator of Mercy Hospital, Pittsburgh, is president. Elected vice-president is Bernard F. Carr, administrator of Altoona Hospital; and treasurer, P. F. Lucchesi, M.D., executive vice president and medical director, Albert Einstein Medical Center, Philadelphia.

Mr. Taylor has held his post at Graduate Hospital since receiving his master of science degree in hospital administration from Columbia University in 1948.



York Hospital Distaffers Win Award

York Hospital Intern and Resident Wives win award—*Mrs. John E. Steers, president of York Hospital's Intern and Resident Wives Association, shows other officers the third place Chapter of the Year Award, which the association received at a national medical convention held in Chicago recently. The Intern and Resident Wives belong to the Woman's Auxiliary to the Student American Medical Association. Seated, right, is Mrs. Harry Speedy, treasurer. Standing, left to right, are Mrs. Jack Kline, service chairman; Mrs. Robert Hannon, recording secretary, and Mrs. John Persing, corresponding secretary.*

Physicians, Nurses Study Mother and Child Health

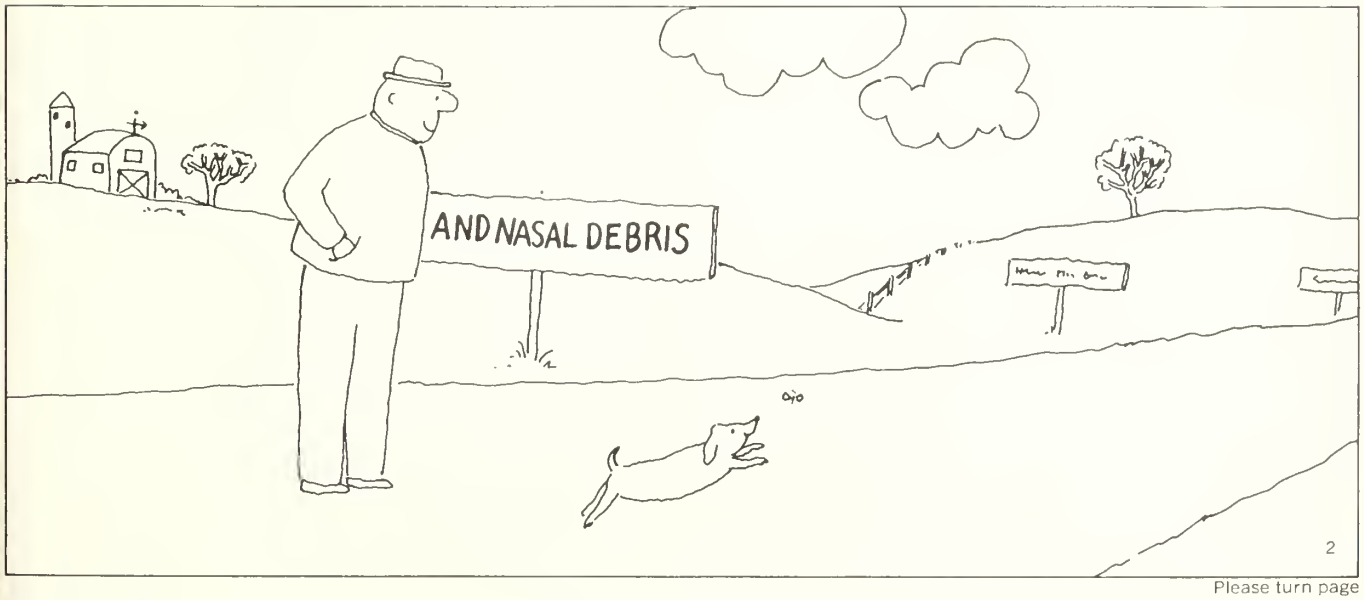
Approximately 100 Pennsylvania physicians and nurses met at the Hershey Motor Lodge recently to study the latest effective procedures for safeguarding the health of babies and their mothers.

It was the tenth annual Institute on Maternal and Child Health sponsored by the Pennsylvania Medical Society, the Pennsylvania Department of Health and the Pennsylvania Academy of General Practice.

Thomas F. Fletchher, Jr., M.D., chief of pediatrics at the Harrisburg Hospital, and chairman of the Commission on Maternal and Child Health of the Pennsylvania Medical Society, said "The Institute provided an opportunity for physicians to review the latest thinking in child and maternal care with noted teaching specialists. The benefits of such conferences are reflected in improved patient care."

The theme of this year's conference was "Screening Methods for Early Identification and Prevention of Problems from Conception to Maturity."

Speakers included Richard A. Paul, M.D., assistant professor of obstetrics and gynecology, Yale University School of Medicine; John C. Sinclair, M.D., assistant professor of pediatrics, College of Physicians and Surgeons, Columbia University; and Gary G. Carpenter, M.D., associate professor of pediatrics, Jefferson Medical College, Philadelphia.



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Medical Educator Group Formation Assisted by PMS

With Pennsylvania Medical Society education programs being directed toward the community hospital level, there is a growing need to rely upon the assistance of the hospital-based medical educator.

As the result of numerous approaches to the PMS Council on Education and Science by directors of medical education, the Council will assist a group of hospital-based medical educators in the formation of a statewide organization in Pennsylvania. At the present time, this group is organized only at the national level.

Temple Director Resigns; To Aid CHS Projects

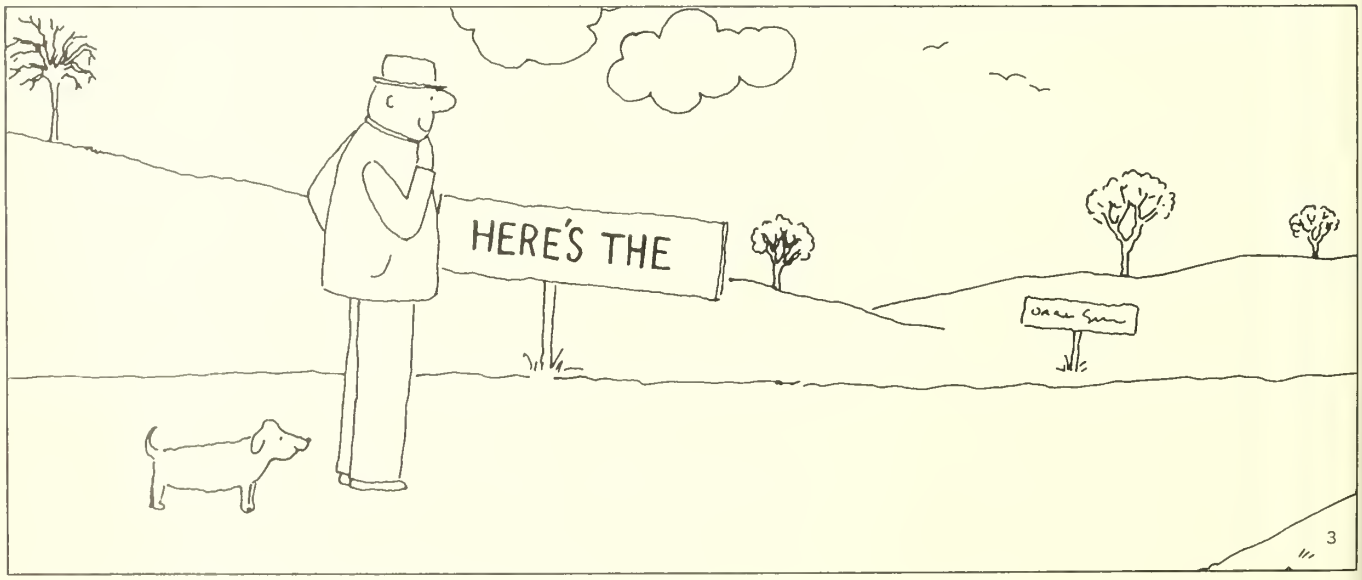
Arthur D. Nelson, M.D., Philadelphia, has resigned as director of Temple University Hospital to devote full time to duties as director of the comprehensive health services project of the university.

L. E. Burney, M.D., university vice-president in charge of health sciences, said Dr. Nelson's new assignment indicates the university's determination "to meet the challenge of urban society and respond to the immediate concern of our neighbors."

Dr. Nelson will work with all colleges of the university and develop a university-wide program for health services and research. He will also continue as program manager for community health services and will work with other program managers in activities relating to the medical school and hospital. Dr. Nelson graduated from the U. S. Military Academy in 1944. He earned an M.S. degree in civil engineering from Harvard University, and an M.D. degree from Temple. At Temple he has served as associate dean of the medical school and as executive director of the hospital.

Geisinger Receives Arthritis Grant

Randolph C. Blodgett, Jr., M.D., *left, rheumotologist at The Geisinger Medical Center, presents a check for $4,950 for research in rheumatoid arthritis to Walter I. Buchert, M.D., right, president, The Institute for Medical Education and Research at Geisinger. The grant was allocated to the Institute by The Arthritis Foundation, central Pennsylvania chapter, to initiate a study of arthritis in central Pennsylvania, where, in the past few years, the incidence and impact of arthritis in rural and less populated areas have become more apparent.*



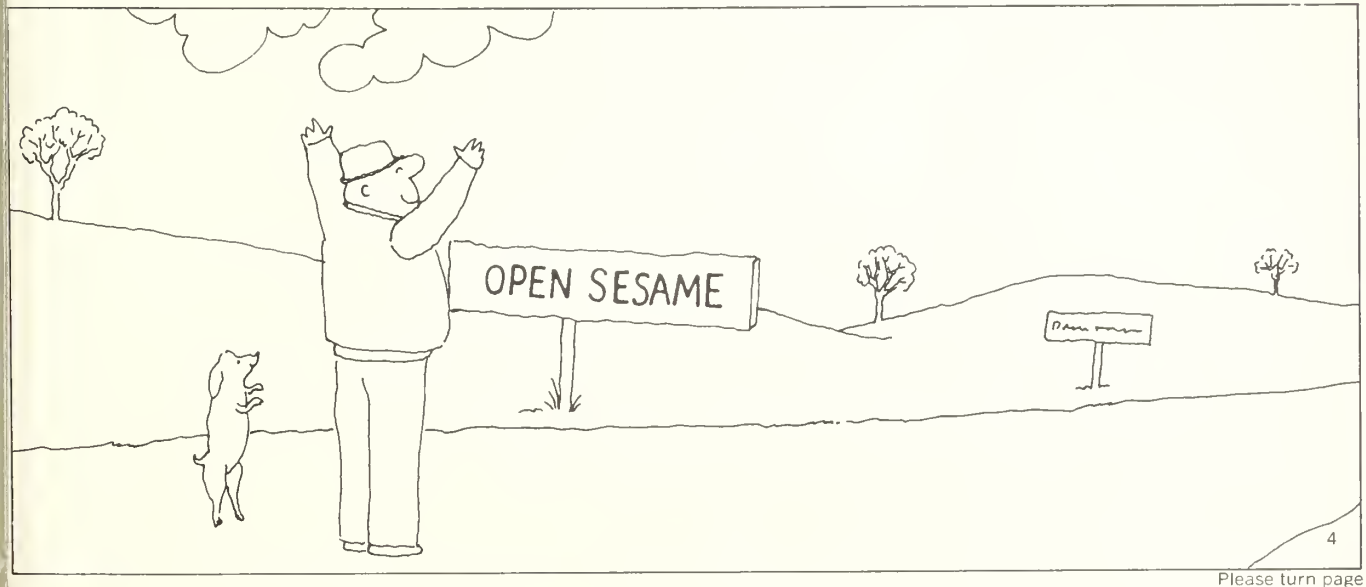
Deadline Set For Grants in Aid of Medical Research

The Life Insurance Medical Research Fund has announced September 5, 1969, as the deadline for receipt of applications for grants in Aid of medical research, to become effective July 1, 1970. These grants are made to non-profit institutions for support of basic research in physiology, biochemistry, and other fields related to medicine. Further information and application forms may be obtained by interested investigators from the Scientific Director, Life Insurance Medical Research Fund, 1030 East Lancaster Avenue, Rosemont, Pennsylvania 19010.

The Fund also offers Medical Scientific Fellowships to medical students willing to prepare for careers in teaching and research by securing both the M.D., and the Ph.D. or its equivalent. The Fellowships offer a maximum of six years of aid; Fellowships may be activated at various stages of the M.D.-Ph.D. training. Each school of medicine is invited to make two nominations for aid to begin July 1, 1970. Deadline for receipt of applications from deans' offices is October 15, 1969. Further information may be obtained from deans in schools of medicine.

Minibus for Minitrips

A new minibus *has been contributed by the Mobil Oil Corporation to Hahnemann Medical College and Hospital for the transport of patients back and forth between the Spring Garden community and Hahnemann. Driver Olga Rivas (left) accepts the keys to the bus from Gilbert B. Myers, M.D. (right), regional medical director, Mobil Oil Corporation, and Patrick B. Storey, M.D. (center), professor and chairman, department of community medicine, Hahnemann. Dr. Storey explained, "The bus is important to the patients because there is no direct public transportation from the Spring Garden area to the hospital . . . in any out-reach project, you are looking for ways to take health care to the patients, but in this case we have to devise a means of taking the patients to the additional care which cannot be rendered in a neighborhood center." Mobil also contributed coupons for 100 gallons of gas.*



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Cancer Society Funds Released From The Test Tube

In a move termed a landmark in the history of achievement of the American Cancer Society, Inc., Sidney Farber, M.D., president of the national organization, announced that $1,000,000 had been allocated by the society to help move research results beyond the test tube and laboratory stage and to apply the information in prevention and treatment of the disease.

Speaking before the national board of directors in Cleveland recently Dr. Farber stated that "This is the year of the patient. Cancer research had advanced greatly and we are ready to use some of this knowledge for the benefit of the patient."

Results of previous laboratory research and information made available by physicians pioneering in the fields of cancer treatment will be utilized in treatment, with full knowledge and consent of the patient.

Dr. Farber noted that in this clinical investigation program, concepts to be tested will be selected by competent medical authorities and treatment conducted under the most rigorous scrutiny.

The $1,000,000 grant, according to Dr. Farber, will not decrease in any way the total amount spent on laboratory research. It will continue, with almost $22,000,000 being allocated by ACS for 1968-69 laboratory research, supported by contributions from the annual fund-raising Crusade. Subsidy for the clinical investigation program will come from legacies to the society.

Delegates from Philadelphia attending the National ACS board meeting were Jonathan E. Rhoads, M.D., director at large of the society and George P. Rosemond, M.D., delegate director to the society.

Dr. Rhoads is the John Rhea Barton Professor and director of the Harrison Department of Surgical Research, School of Medicine, University of Pennsylvania. He is president elect for 1970 of the national body of the American Cancer Society, Inc.

Dr. Rosemond is professor and chairman of the department of surgery, Temple University School of Medicine and Hospital. He is immediate past-president of the Philadelphia Division of the Society.

State Health Council Approves Regional Group Planning Funds

The state Advisory Council for Comprehensive Health Planning approved the applications of two regional groups for planning funds at its recent meeting in Camp Hill.

The two groups are the East Central Pennsylvania Areawide Committee for Regional Medical Programs and Comprehensive Health Planning, Inc., and the Western Pennsylvania Regional Comprehensive Health Planning Agency, Inc.

The East Central Pennsylvania Committee is applying to the U.S. Public Health Service for a $39,399 grant to organize an agency in six counties: Berks, Carbon, Lehigh, Monroe, Northampton, and Schulykill.

The Western Pennsylvania Agency is applying for $324,000 to operate an agency in twelve counties: Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Somerset, Washington, and Westmoreland.

The two groups, when funded by the Public Health Service, will conduct comprehensive health planning, which includes the environmental, physical, mental, and socioeconomic aspects of health. The grants will be matched equally by contributions from local, private, and public sources.

FDA Challenged

Upjohn Files Suit; Balks At Panalba Market Removal Without Hearing

The Upjohn Company has filed suit in the Federal District Court for the western district of Michigan to enjoin the Food and Drug Administration from removing the combination antibiotic product Panalba from the market prior to a hearing.

The product, containing two effective antibiotics tetracycline and novobiocin, had been ordered off the market by June 14 by the Food and Drug Administration.

According to R. T. Parfet, Jr., president and general manager of the pharmaceutical company, the basic question involved is whether a regulatory agency has the right to order a widely-used product from the market summarily without a hearing.

"There is no question but that the two antibiotics combined in the Panalba capsule are effective in the treatment of certain bacterial infections such as middle ear infections," Mr. Parfet said, noting that the product, which has been on the market since 1957, has been prescribed by thousands of physicians for millions of patients. "It just would not have been used to the extent that it has if the effects of the treatment were not apparent to the patient and obvious to the physician," he added.

"Furthermore," Mr. Parfet said, "the safety of the product Panalba is comparable to that of other widely-used antibiotics. There is no question but that all antibiotics have side effects. But when a product has been prescribed widely in an amount approaching a billion doses during more than a decade, time for a hearing to review all medical and scientific data appears justified."

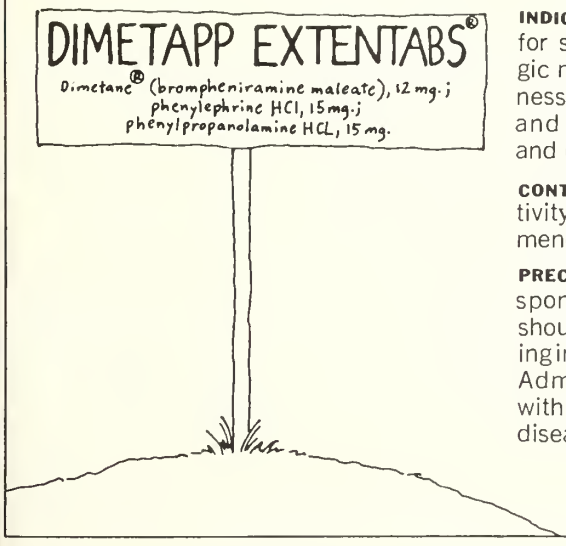
First Byberry Patient Graduates

Miss Alice McGonigle, *first patient at Philadelphia State Hospital, Byberry, to receive a high school diploma under the hospital's new high school equivalency program in cooperation with the Commonwealth's Department of Public Instruction, receives congratulations from Daniel Blain, M.D., director; J. Pius Barbour, Jr., M.D., clinical director of the unit where Miss McGonigle has been a patient, and Dr. Burton Cahn, director of education and training at Byberry.*

Temple Sciences Bldg. Dedicated

A $5.8 million, nine-story building, combining traditional lecture halls with a modern concept of multi-discipline satellite laboratories was dedicated, May 3, by Temple University School of Medicine.

The building will be used to teach basic sciences to expanding classes of freshmen and sophomores.



INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, hayfever and conjunctivitis.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

DOSAGE: 1 Extentab morning and evening.

SUPPLIED: Bottles of 100 and 500.

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PENNSYLVANIA MEDICAL SOCIETY

CLINICAL THERAPEUTICS—1969

at the Host Farm Resort Motel, Lancaster, Pennsylvania

MONDAY, SEPTEMBER 15

9 a.m. to 12:30 p.m.—PMS Seminar
"Antibiotics, Bacteria and the Host"
2 p.m. to 4:30 p.m.—Specialty Seminars
Allergy
Arthritis—Physical Medicine & Rehabilitation—Rheumatism
Chest Physicians—Thoracic Society
College of Physicians—Internal Medicine
Pediatrics
9 p.m. to 10:30 p.m.—Special Program
"The Role of PMS in Education"

TUESDAY, SEPTEMBER 16

9 a.m. to 12:30 p.m.—PMS Seminar
"Hormones—The Miracle Has a Price"
2 p.m. to 4:30 p.m.—Specialty Seminars
Arthritis—Physical Medicine & Rehabilitation—Rheumatism
Cancer
Chest Physicians—Thoracic Society
College of Physicians—Internal Medicine
Psychiatry
Urology
All Day—Nurses Seminar

WEDNESDAY, SEPTEMBER 17

9 a.m. to 12:30 p.m.—PMS Seminar
"Administering to the Aching and Jittery Heart"
2 p.m. to 4:30 p.m.—Specialty Seminars
Colon and Rectal Surgery
Heart Association
Ophthalmology and Otolaryngology

THURSDAY, SEPTEMBER 18

9 a.m. to 12:30 p.m.—PMS Seminar
"Special Problems of Drug Usage"
2 p.m. to 4:30 p.m.—Specialty Seminar
Anesthesiology—Chest Physicians—Thoracic Society
Dermatology

Dulcolax®...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl

ER LICENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 DU-6681

Clues to PVD in the geriatric smoker

In studies on peripheral vascular disease—a common by-product of the degenerative aging process—considerable attention has focused on the important role of smoking in the progression of the disease. Although it may not be etiologic, smoking is widely recognized as a prominent contributing factor.[1]

Skin blood flow—significant factor in PVD. Cutaneous digital vasoconstriction caused by nicotine has been observed both in normal subjects and in patients with peripheral vascular disorders.[1,2] Among patients with peripheral vascular disease, however, age and the severity of the disease appear to modify the effects of nicotine. For example, in a study of older patients with *marked* peripheral vascular disease,[3] changes induced by smoking were not statistically significant for the group as a whole. This was explained on the basis of decreased skin reactivity. *Smoking is not permissible in any stage of the disease,* since even "... minimal reduction in blood flow in patients with ischemic limbs may produce a further reduction in tissue nutrition, and thus may be another case of the proverbial straw on the camel's back."[3]

In another study of patients with peripheral vascular disease,[4] the investigators stress that decreased skin blood flow during smoking "... is the factor of most importance to the patient with peripheral vascular disease." *While such patients may adjust to the discomfort of vascular insufficiency in skeletal muscle, decreased skin blood flow may often lead to severe symptomatology.*

More and more physicians have adopted the practice of investigating for peripheral vascular disorder when confronted with a geriatric patient who is a habitual smoker. Once a diagnosis is established, therapeutic measures are directed toward increasing the peripheral circulation and appropriate management of the patient's general medical needs. These include the important safeguards of keeping warm and refraining from smoking.

Professional model posed for illustration.

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.
Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.
Selectivity of action—relaxes the musculature of peripheral blood vessels.
High degree of safety—side effects seldom require discontinuation of therapy.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.
Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.
Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.
Dosage: 1 or 2 Timespan Tablets morning and night.
How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt, bottles of 50.

References: (1) Roth, G. M.; Shick, R. M., and Secrest, R. R., in James, G., and Rosenthal, T., eds.: *Tobacco and Health*, Springfield, Ill., Charles C Thomas, 1962, pp. 311-322. (2) Entmacher, P. S.: Proc. Med. Sect. Amer. Life Convention 51:149, 1963. (3) Freund, J., and Ward, C.: Ann. New York Acad. Sci. 90:85, 1960. (4) Coffman, J. D., and Javett, S. L.: Circulation 28:932, 1963.

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Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.

newsfronts

Donaldson Awards Presented

Receiving Donaldson Award *plaques and cash prizes at the Pennsylvania Press Conference in State College recently were, left, William E. Jones, and center, Claude Lewis. George E. Farrar, Jr., M.D., PMS president, right, presented the awards. Mr. Jones, editor of the weekly Windber Era supplement of the Johnstown Tribune-Democrat, received the award for a series of articles entitled, "A Look at What Makes a Community Hospital Tick.' The winning entry by Mr. Lewis was a series called "The Deadly Trap of Drug Addiction," which appeared in the Philadelphia Bulletin.*

Retiring County Secretary Receives Strittmatter Honors

William F. Irwin, executive secretary of the Philadelphia County Medical Society, who will retire later this year after thirty-one years of service, has been given the society's annual Strittmatter award. He is the first nonphysician to receive the award, which was established by the late Isador P. Strittmatter, M.D., when he was the society's president in 1923, for "extraordinarily meritorious service redounding to the credit of the medical profession." The award consists of a gold medal and a scroll.

Irwin was chosen because, in the words of the awards committee, "he has befriended and favored every physician at one time or another either directly or indirectly," during his thirty-one years of service to the society.

Society President Theodore H. Mendell, M.D., said, "I know of no one who has achieved the high measure of affection which is borne for him by our members."

WMC Bestows Degree On Dr. Sturgis

Dr. Sturgis

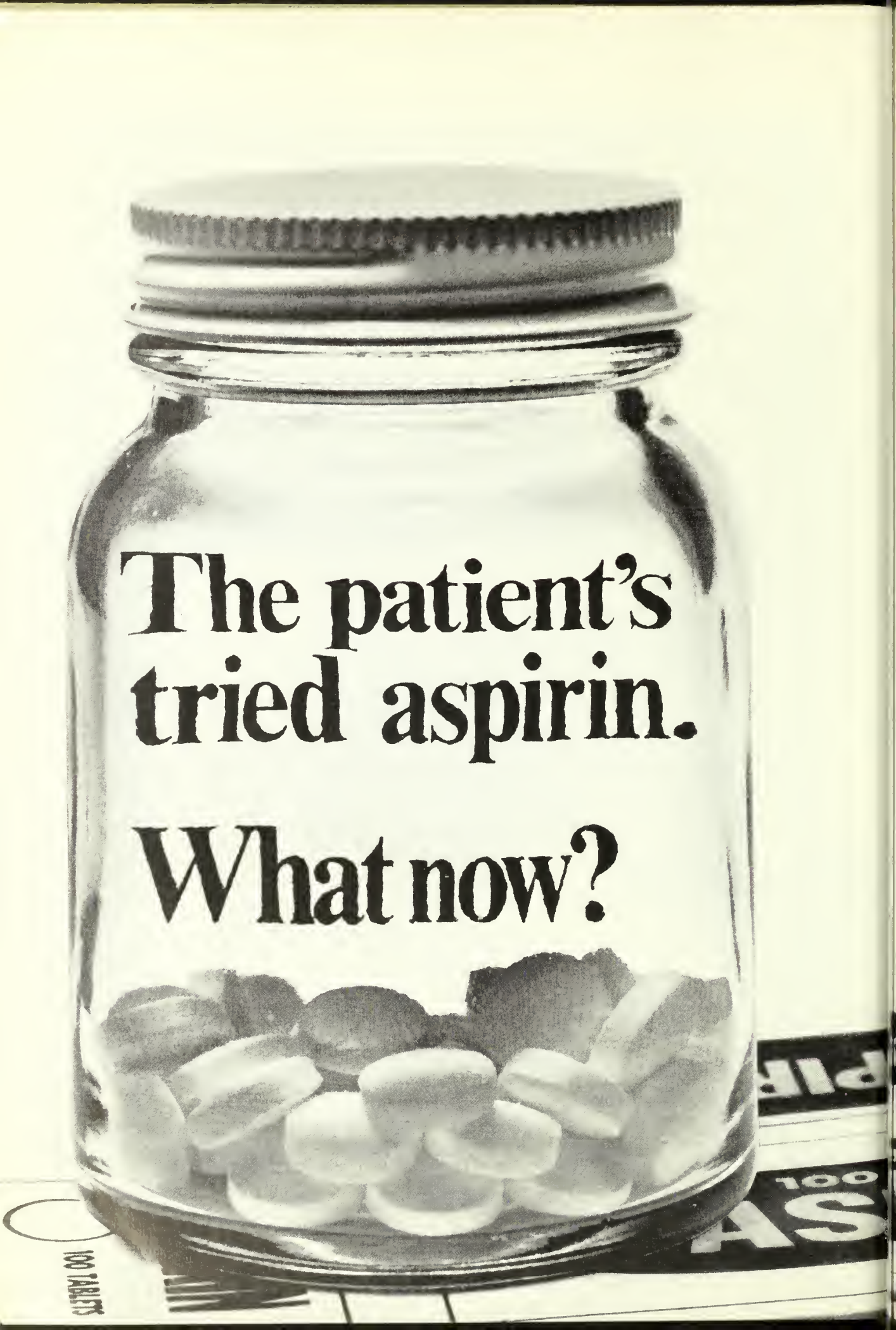
Katharine R. Sturgis, M.D., first woman president of the Philadelphia Medical Society, received an honorary degree from Woman's Medical College of Pennsylvania at commencement ceremonies held last month. Glen R. Leymaster, M.D., WMC president and dean, awarded the degree.

Dr. Sturgis, who received her M.D. from WMC in 1942, earned a Master's Degree in Public Health in 1954, overcoming numerous obstacles to do so. She returned to college, after a thirteen-year interim, during which she married and had a son and a daughter. She completed her premedical studies and despite being stricken with tuberculosis, and having to spend two years in a sanatorium she completed her medical studies, and received her medical degree in 1942.

Turning a handicap into an asset, she entered the specialty of pulmonary diseases. Convinced that new infections must be stopped, she returned to Philadelphia after receiving training in the specialty in Detroit, Mich., and assumed direction of mass x-ray surveys begun primarily for early detection of tuberculosis. She became increasingly interested in lung cancer, and has done major research in the areas of tuberculosis and lung cancer detection.

In 1952 she was appointed professor and chairman of the department of preventive medicine at Woman's Medical College, which position she still holds.

Dr. Sturgis is president-elect of the American College of Preventive Medicine and holds fellowships in numerous learned societies, as well as serving as editor of the *Archives of Environmental Health*, making her the only woman editor of a major medical journal in the nation.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(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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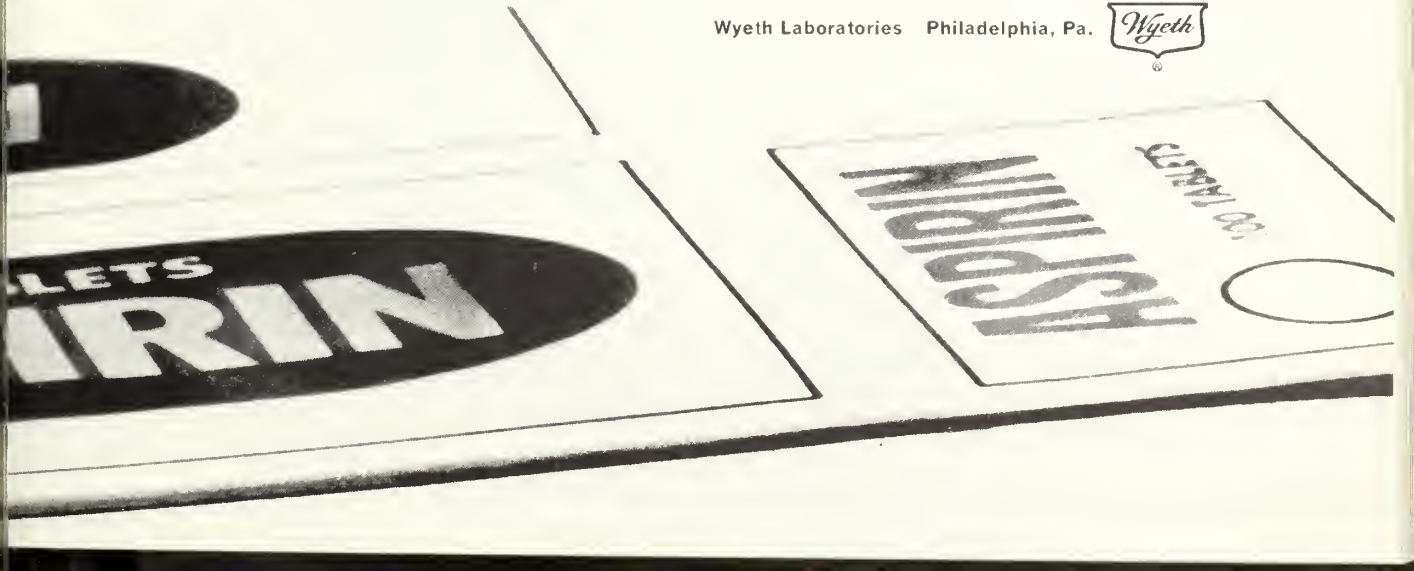

close-up/MD's

Francis S. Cheever, M.D., vice chancellor for the health professions, and dean of the School of Medicine at the University of Pittsburgh, has been elected to membership in the American Academy of Arts and Sciences. One of America's oldest learned societies, the American Academy was founded by John Adams in 1780 and has included in its membership such distinguished Americans as George Washington, Oliver Wendell Holmes, Horace Mann, and Martin Luther King, Jr. Dr. Cheever came to the university in 1950, and became dean of the School of Medicine in 1958. He has been vice-chancellor of the health professions since 1967. He is an authority in the field of microbiology, and is a member of a number of medical and professional societies.

DR. CHEEVER

Harry R. Morse, M.D., Williams S. Gibson, Jr., M.D., and **William A. Rusin, M.D.,** all on the staff of the department of otolaryngology, Geisinger Medical Center, Danville, recently had a paper published in *Eye, Ear, Nose and Throat Monthly*. Their subject was, "Diseases of the Esophagus."

Wesley W. Park, M.D., Philadelphia, Jefferson Medical College student, recently won second prize in medical photography in the 1969 Medical Art Award Competition sponsored by the Student American Medical Association, through the cooperation of Eaton Laboratories.

John Steers, M.D., surgical resident at York Hospital, received a $200 first place award from the Central Pennsylvania Chapter of the American College of Surgeons recently for his paper, "Pulmonary Thromboembolism." This is the fourth year in a row that a York Hospital doctor has received the award.

Miles O. Colwell, M.D., Pittsburgh, was one of five named recently to the board of directors of the Industrial Medical Association, international association of physicians in industry. Dr. Colwell is vice-president and medical director of the Aluminum Company of America.

Frank I. Marlowe, M.D., Philadelphia, participated as a member of the teaching faculty of an advanced seminar on rhinoplasty and otoplasty held recently in New York City. The seminar was conducted for specialists in the field by the American Academy of Facial Plastic and Reconstructive Surgery, Inc. Dr. Marlowe is stationed at the U.S. Naval Hospital in Philadelphia, where he interned and did his residency after receiving his degree from the University of Pittsburgh School of Medicine.

DR. MARLOWE

The appointment of **Dr. Philip E. Palmer** as professor of radiology at the University of Pennsylvania School of Medicine, has been announced by **Richard H. Chamberlain, M.D.,** department chairman. An Englishman, Dr. Palmer has spent the last fourteen years in Rhodesia and the Union of South Africa. His work here will be primarily clinical and instructive, but he will continue a research project, begun in South Africa, on the distribution of diseases throughout that continent. He is a graduate of Westminster Medical School, University of London.

Jonas Salk, M.D., revisited Pittsburgh recently to receive the second Mellon Institute Award and to deliver the annual Robert K. Duncan Memorial Lecture. He founded the Salk Institute for Biological Studies in San Diego, Calif., in 1963, when he left Pittsburgh, and continues his research there.

Richard B. Magee, M.D., Altoona, presided at the thirty-ninth annual meeting of the Wainwright Tumor Clinic in Altoona. Among speakers from throughout the nation were **Charles A. Waltman, M.D.,** Easton, and **N. Henry Moss, M.D.,** Philadelphia. Elected officers were **Horatio T. Enterline, M.D.,** Philadelphia, president; **William T. Douglas, Jr., M.D.,** Harrisburg, president-elect; **William C. Beck, M.D.,** Sayre, vice-president; **David G. Beiler, M.D.,** Danville, secretary, and **George R. Greenwood, M.D.,** Bethlehem, treasurer.

J. Joseph Danyo, M.D., York Hospital staff physician, became a certified diplomate of the American Board of Orthopedic Surgery recently, after passing a board examination. Dr. Danyo has been on the hospital's medical staff for two years. After graduating from Jefferson Medical College, and completing his residency in orthopedic surgery, he received a fellowship in hand surgery. He is president of the J. L. Posch Hand Society, Detroit, Mich., and is a member of the Philadelphia Orthopedic Society.

DR. DANYO

James A. Collins, Jr., M.D., Danville, director of the department of internal medicine, Geisinger Medical Center, was installed as president of the Pennsylvania Society of Internal Medicine at its seventh annual meeting held recently at Host Farm Motel, Lancaster. He succeeds Robert S. Pressman, M.D., Philadelphia.

Harry C. Winslow, M.D., retired Meadville surgeon, has received widespread response to his paper, "Pregnancies following Hysterectomy," which appeared in the January issue of PENNSYLVANIA MEDICINE. Letters from all over the nation and from a number of foreign countries have come to him, and the article has been quoted in several professional journals.

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Ethinyl Estradiol . . . . . 0.02 mg
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INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen; only steroid effect remains. Geriatrics, post operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRAINDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

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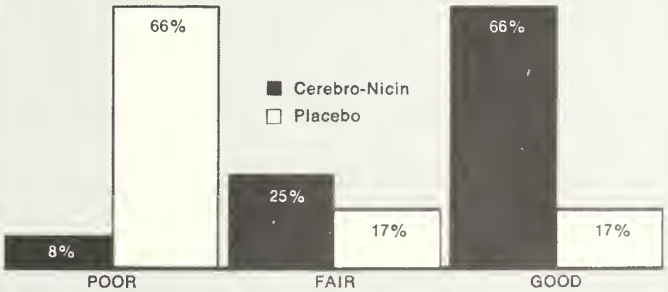
A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
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Thiamine HCl	25 mg.
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Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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brand of tybamate

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PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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close-up/MD's

WELCOME, NEW MEMBERS!

These MD's have joined the State Society in recent months:

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AUGUSTO D. CASTRO, M.D., 5230 Centre Ave., Pittsburgh 15232.

SIOK C. L. CHUA, M.D., 320 E. North Ave., Pittsburgh 15212.

ROBERT W. CLEVENGER, M.D., 550 Grant St., Pittsburgh 15219.

JOEL DAVIDSON, M.D., 685 1-A Elmspring Court, Pittsburgh 15220.

MICHAEL L. GERBER, M.D., 655 Oaklyn Court, Pittsburgh 15220.

ROBERT B. GREER, III, M.D., 125 DeSoto St., Pittsburgh 15213.

ROBERT A. HINGSON, JR., Magee-Womens Hospital, Pittsburgh 15213.

TIMOTHY JANEWAY, M.D., 372 S. Winebiddle St., Pittsburgh 15224.

STEPHEN J. KARPINSKI, JR., M.D., 108 Yellowstone Dr., Pittsburgh 15235.

ELMER H. MALOY, M.D., 501 N. State St., Clairton 15025.

LUIS J. MAYORAL, M.D., Mercy Hospital, Pittsburgh 15219.

RAUL MERCADO, JR., M.D., Presbyterian University Hospital, Pittsburgh 15222.

WILLIAM J. MEYER, M.D., 944 Vista Glen Dr., Bethel Park 15102.

JOHN R. MISAGE, M.D., Apt. B7, 4403 Center Ave., Pittsburgh 15213.

JAMES A. NICOTERO, M.D., 978 Center Oak Dr., Pittsburgh 15237.

WILLIAM F. POMPUTIUS, JR., M.D., 346 Locust St., Pittsburgh 15218.

HOWARD E. REIDBORD, M.D., Montefiore Hospital, Pittsburgh 15213.

GEORGE SABEH, M.D., 496 Filmore Rd., Pittsburgh 15221.

MAX W. SAFLY, M.D., Presbyterian University Hospital, Pittsburgh 15213.

PAULITA M. YUVIENCO, M.D., 3 Allegheny Center, Apt. 106, Pittsburgh 15212.

WILLIAM A. ZELEZNOCK, M.D., Allegheny General Hospital, Pittsburgh 15212.

BEAVER COUNTY:

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(Continued next page)

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URISED rapidly exerts spasmolytic action, relieving pain and discomfort of urgency, frequency, and burning on urination. Rapid acting URISED exerts antibacterial action against uropathogens susceptible to methenamine and methylene blue, in an acid medium.

URISED is safe . . . especially useful in long-term management of chronic cases; as a prophylactic measure with catheterization or after instrumentation. No systemic reactions or bacterial resistance have been reported.

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Each blue-coated tablet contains active:

Atropine Sulfate	0.03 mg.	Methylene Blue	5.4 mg.
Hyoscyamine	0.03 mg.	Phenyl Salicylate	18.1 mg.
Methenamine	40.8 mg.	Benzoic Acid	4.5 mg.

PRECAUTIONS: Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

SIDE EFFECTS: Neither irritation nor other untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—Initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

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William J. Kirsch, M.D., Altoona Hospital, Altoona 16603.
A. Leonard Zimmerman, M.D., 501 Howard Ave., Altoona 16601.

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Enrico J. DiRienzo, M.D., 1202 Pond St., Bristol 19007.
Daniel T. Erhard, M.D., 502 Montgomery Ave., Haverford 19041.
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Thomas J. Magnani, M.D., 119 Harris Dr., State College 16801.

CHESTER COUNTY:

Marcus P. Rosenblum, M.D., V. A. Hospital, Coatesville 19320.

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J. Campbell Martin, M.D., Department of Pathology, Bloomsburg Hospital, Bloomsburg 17815.

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Dante J. Bevilacqua, Jr., M.D., 203 Turner Rd., Wallingford 19086.
Chi Jen Chen, M.D., 207 Magnolia Terrace, Upper Darby 19082.
Ping-Wen Kuohung, M.D., Fitzgerald-Mercy Hospital, Darby 19023.

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Charles Ferris, M.D., 121 W. Tenth St., Erie 16501.
Francis O. Lamb, M.D., 121 W. Tenth St., Erie 16501.
Forrest C. Mischler, M.D., R.D. 1, Godfrey Rd., Lake City 16423.

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(Continued page 58)

In the complex picture of moderate to severe anxiety...

there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

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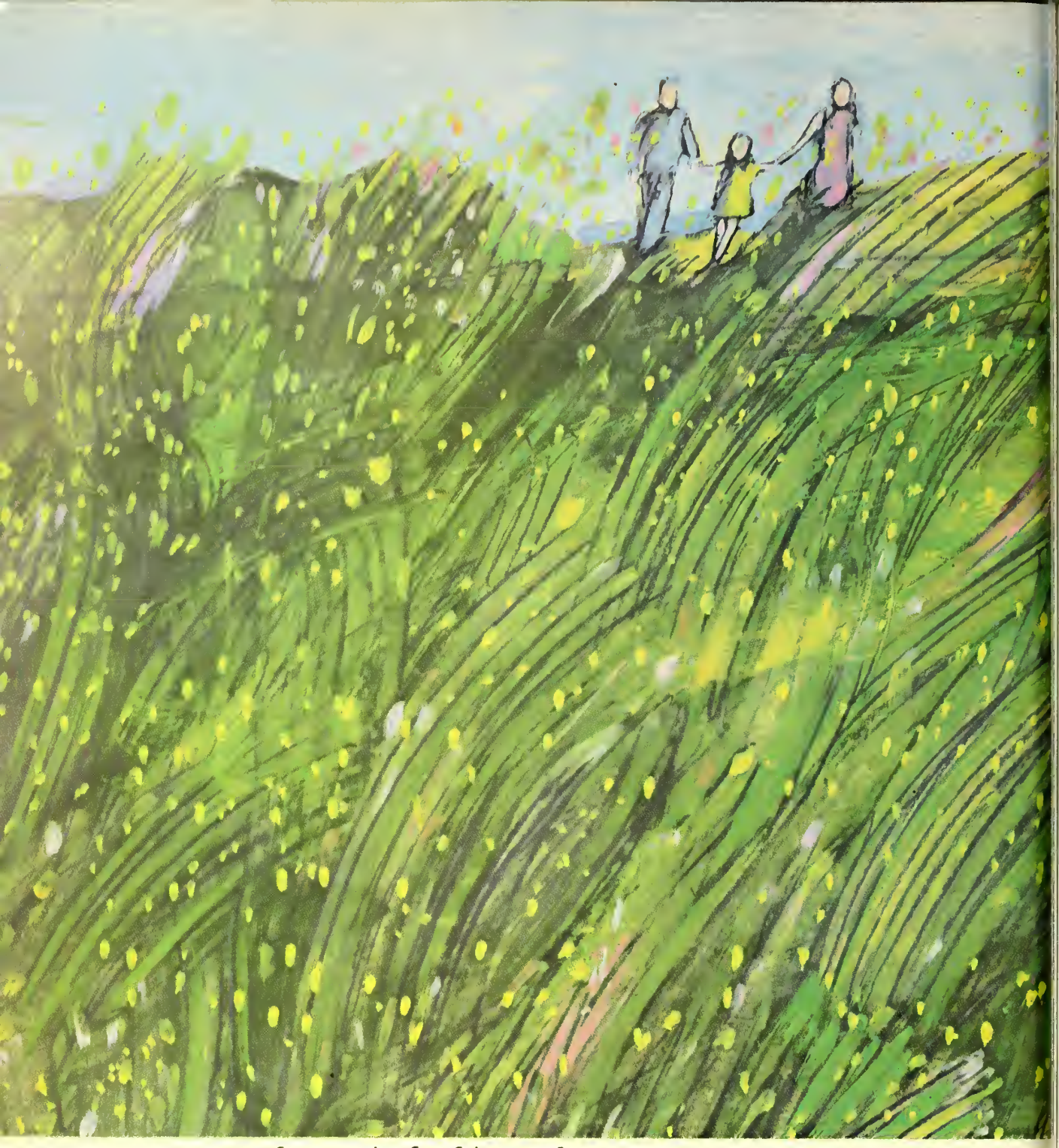

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NTZ Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:

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Neo-Synephrine® (brand of phenylephrine) HCl, 0.5% (adult strength), decongestant
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Zephiran® (brand of benzalkonium as chloride, refined) Cl, 1:5000, antiseptic wetting agent

Treatments with NTZ should be repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms and overdosage should be avoided. Available in squeeze bottles of 20 ml. and 1 oz. bottles with dropper.

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your patient can feel better while she's getting better

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Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial* bulging fontanels in young infants. *Teeth* yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

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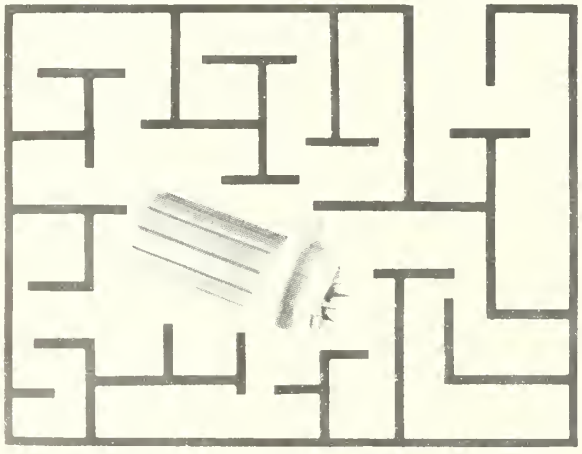

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PENNSYLVANIA MEDICINE editorials

The Arthritides

There is a distinct fascination in the game of picking the biggest or the smallest, the most frequent or the most important. In this game, the disabilities of men have not been neglected. The commonest disease of mankind is said to be dental caries and it may well be a fact. But, aside from the game, and in all humanity, we can make a strong case for arthritis as among the problems which cry out for solution. It is one of our most widespread, most painful, most disabling and most debilitating deviations from health.

The number of people who suffer from the diseases which come under the classification of arthritis and rheumatism is vast and the amount of suffering which comes about because of these scourges of our race is literally incalculable. Not only this, but the majority of the conditions which fit under our umbrella terminology are long lasting in the extreme. And, since they are very painful, indeed, they may well qualify for the highest mark for superlative damage to our race. In prevalence, chronicity, painfulness and resistance to therapy we can well award arthritis and rheumatism the prize.

In spite of the fact that practitioners devote so much time to relief of symptoms, we have done but little during the modern advance of scientific medicine to help the arthritic. Not only have we failed to find satisfactory palliation for his suffering; our research funds have tended to be directed into channels where the results would be more spectacular. We could do worse than turn our attentions to the arthritides.

CBL

Routine Sigmoidoscopy

The value of routine sigmoidoscopy has long been unquestioned. Despite this fact, many physicians still do not include it as part of a complete physical examination. Some of the reasons given for this omission are: (1) difficulty in preparing the patient, (2) inconvenience of performing examination, and (3) poor patient acceptance. I would like, therefore, to again describe the ease with which this procedure can be carried out and the worthwhile results obtained.

In order to assure adequate preparation of the bowel, each patient is sent a form letter containing, among other items, the instructions to take an enema two hours prior to the examination. A single Fleet enema has proven quite satisfactory. We specifically do not require repeated enemas until clear. As a result of this simple expediency, it has been our experience that the colon is adequately prepared for sigmoidoscopy in approximately 80 per cent of the patients on their initial visit.

The sigmoidoscopic examination is carried out as the last part of the physical examination. The patient is placed in the lateral Sim's position (either right or left). This position is more comfortable for the patient and has greater patient acceptance than the knee-chest position. By utilizing this position, the study can be performed on any office examining table thereby eliminating the necessity of an expensive table that has only limited use. The examiner may sit or kneel beside the examining table.

Only patients without colon symptomatology have been included in the results which follow. The patients with symptoms such as melena, change in bowel function, and abdominal pain have been excluded from this study. One thousand consecutive asymptomatic patients were examined between 1955 and 1964. The average age was 45; the oldest 82; the youngest 13.

A twenty-four centimeter sigmoidoscope was passed an average of twenty centimeters. A vigorous attempt to pass the instrument the last few centimeters is not justified in this routine examination.

This series disclosed ten cases of benign adenomatous polyposis, six cases of carcinoma in situ of adenomatous polyposis as well as three cases of carcinoma of rectum or sigmoid requiring abdomino-peritoneal resection. There was also one case of familial polyposis with multiple areas of carcinomatous change. One case of ulcerative colitis was found.

The cases of carcinoma in situ of adenomatous polyposis and the cases of rectal or sigmoid carcinoma are all available for follow-up. One of these, an 82 year old male, died two years after operation following a cerebral vascular accident. The remainder are all living and well and free of disease. The one case of familial polyposis was thirty-nine years of age at the time of the first examination. An immediate colectomy was done but the patient

(Continued on page 62)

Sometimes your patient cannot afford to take another corticosteroid

When corticosteroids are used for long-term therapy, as in rheumatoid arthritis, salt and water retention can be a very real problem, especially for those individuals who have concurrent cardiovascular disease with edema.

If triamcinolone—ARISTOCORT—is the corticosteroid specified, this problem can be minimized—as can the problems of undesirable euphoria, overstimulation of appetite and excessive weight gain sometimes seen as the result of therapy with other agents. On the other hand, side effects, including myopathy, characteristic of cortisone-like drugs may occur.

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Precautions: General precautions common to all corticosteroid therapy should be observed, including those pertaining to growth suppression in children during prolonged use. Patients should be observed carefully, a few may react unfavorably under certain conditions. If severe reactions, or idiosyncrasies are encountered, use should be discontinued and appropriate measures instituted. It is not the agent of choice in adrenocortical insufficiency. Since glucocorticoids depress adrenocortical function, it is important that therapy be withdrawn gradually, especially after prolonged treatment. Adequate supportive measures and increase in dosage, or supplementation with cortisone, cortisol, or ACTH are indicated when patients are subjected to unusual stress, such as trauma or surgery, while on active therapy or up to a year after discontinuation of therapy. The possibility of development of infectious disease during glucocorticoid therapy requires careful observation of the patient, because the initial signs and symptoms of the infection may be obscured. Appropriate antibiotic therapy should be instituted.

Side Effects: Moon face, acne, flushing of the face, buffalo hump, osteoporosis, spontaneous fractures, amenorrhea, aggravation of infection, psychic disturbances, thromboembolism, peptic ulcer, gastrointestinal hemorrhage, increased intracranial pressure, headache, insomnia, fatigue, purpura, hirsutism, vertigo, leukopenia, and increased intraocular pressure. Subcapsular cataracts may be formed on high dosages over long periods. A mild depression may occur. Necrotizing angiitis is rare. Ulcerative esophagitis and acute pancreatitis have occurred. Long-term administration results in definite catabolic effects, as indicated by negative protein and calcium balance. This catabolic effect coupled with anorexia may produce weight loss which is undesirable in some patients. A steroid myopathy with advanced muscle weakness may involve muscles of thighs, pelvis, and low back. Fluid and electrolyte balance differs from older corticosteroids in that it promotes mild sodium excretion. Patients with sodium retention and edema, either from underlying diseases or from previous therapy with other corticosteroids, will frequently lose weight and show increased urinary output associated with some sodium diuresis during the first 3 to 7 days of therapy. This effect will not be seen in patients with decreased glomerular filtration. Potassium balance is not affected under ordinary dosage circumstances; and potassium supplementation ordinarily is not necessary, unless the dosage exceeds 36 mg. per day for more than 14 days. Hypertension and edema are not commonly observed—they should not be used as indications of overdosage.

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had multiple areas of carcinomatous change and died of his disease one year later. The one case of ulcerative colitis, after repeated recurrence of the disease, required a colectomy with ileostomy. She is living and well at the present time.

In the hands of the average physician, a sigmoidoscopy examination is no more difficult or time consuming than a vaginal examination. In the series presented, the incidence of carcinoma in situ was six per thousand and the incidence of frank carcinoma with invasion was four per thousand. This experience compares favorably with the results of findings of the Papanicolaou smear for cancer of the cervix. In a series of 35,748 women screened by this method, invasive carcinoma was found in 1.2 per thousand and carcinoma in situ was found in 4.2 per thousand. Routine sigmoidoscopy, in asymptomatic patients, has the same significance relative to distal colon lesions as does the Papanicolaou smear to cervical lesions.

David S. Masland, M.D.
Carlisle

Involvement and Leadership

Medicine is not a static profession, and recent scientific advances have been phenomenal. But the changing patterns of medical practice are more subtle and perhaps less evident to the physician whose chief preoccupation is with the care of the patient.

The curriculum of most medical schools has placed little emphasis on the social and economic problems which effect the availability and delivery of health services. This deficiency is being corrected slowly but the physician in practice must, as a socially responsible individual and as a member of organized medicine, give concentrated attention and intensive study to these problems.

The general practitioner is disappearing. I don't believe this trend can be arrested or reversed. The increasing scope of medical knowledge leads one to doubt the feasibility or desirability of attempting to do so. Much of general practice has gravitated to the hospital emergency room. The growth of ambulatory care centers in or adjacent to hospitals leads to the conclusion that health care in the future will tend to be hospital based. This has many desirable features. A successful transition will require more interest and greater involvement in hospital operation of physicians and more dependence on medical advice by hospital boards and administrators. There will be more grouping and closer associations among physicians. Interrelationships will vary. Recent studies have shown that the cost savings claimed by proponents of prepaid group practice have not resulted.

The philosophy of cooperative planning within and among hospitals has been generally accepted. The intra-hospital planning must involve the medical staff, administration, board and all ancillary and voluntary services which are important to an institution's success. The same groups must be involved in inter-hospital planning. If physicians are to plan, it is essential that they participate in the implementation of the recommendations. This implies medical staff representation on hospital boards and physician representation on area boards.

There have been gaps in the health care of the poor, as well as deficiencies in housing, education, transportation, opportunity, et cetera. Government has indicated an intention to make the poor person unidentifiable in our society. One wonders if all the inequities were corrected, whether it would be possible to eliminate established patterns of health care which have become traditional with both consumer and provider. Nevertheless it is our obligation to guide, direct and explore various approaches to improvement of the health care of the poor.

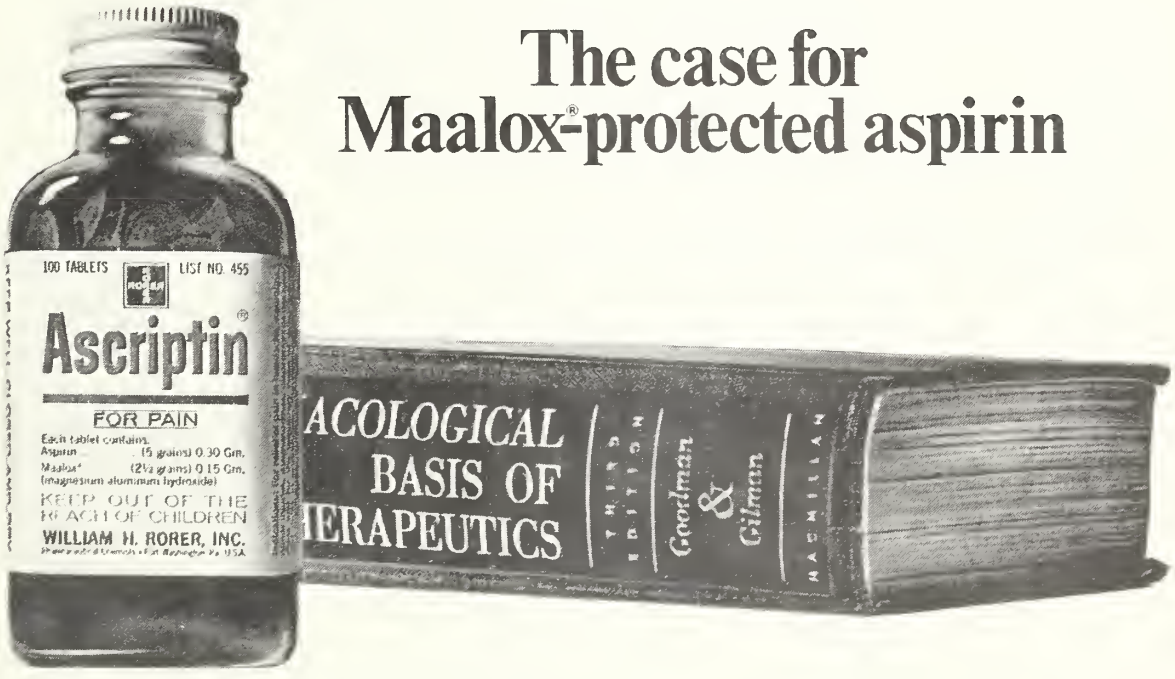
Medicare has been in operation since July, 1966. Physician certification and the requirement of a receipted bill for payment have been eliminated. Costs, as predicted in testimony before the law was passed, have far exceeded estimates. Legislation to include the disabled probably will be introduced in Congress soon.

Pennsylvania Medicaid, a combined federal and state program to subsidize the medically indigent, has been handicapped by budgetary difficulties. The intent of Congress is to pay the provider his usual fee for service. Whether this will be financially possible without limiting the scope of services or lowering the qualifying income to an unrealistic level will be revealed in time. If physicians will provide usual and customary services to the recipients of this subsidy it may encourage the legislators to supply sufficient funds to pay usual and customary fees. The reverse could be true also.

The Regional Medical Program and Comprehensive Health Planning are still in the formative, organizational stages. Some feel that there is a significant overlap and that they may be eventually a single program. It is too soon to predict whether the laudable objectives of their sponsors will be achieved or a gigantic boondoggle will have been created with the results not justifying the considerable expenditure of tax monies. One certainty is that there is no possibility of their success without guidance, interest, direction and participation by physicians at all levels of planning and operation.

Eugene A. Conti, M.D., Immediate Past President
Allegheny County Medical Society
Reprinted from:
Allegheny County Medical Society Bulletin

The case for Maalox®-protected aspirin



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1. Woodbury, D. M.: *In* The Pharmacological Basis of Therapeutics, 3d ed., 1965, L. S. Goodman and A. Gilman, eds., Macmillan, New York, p. 319.

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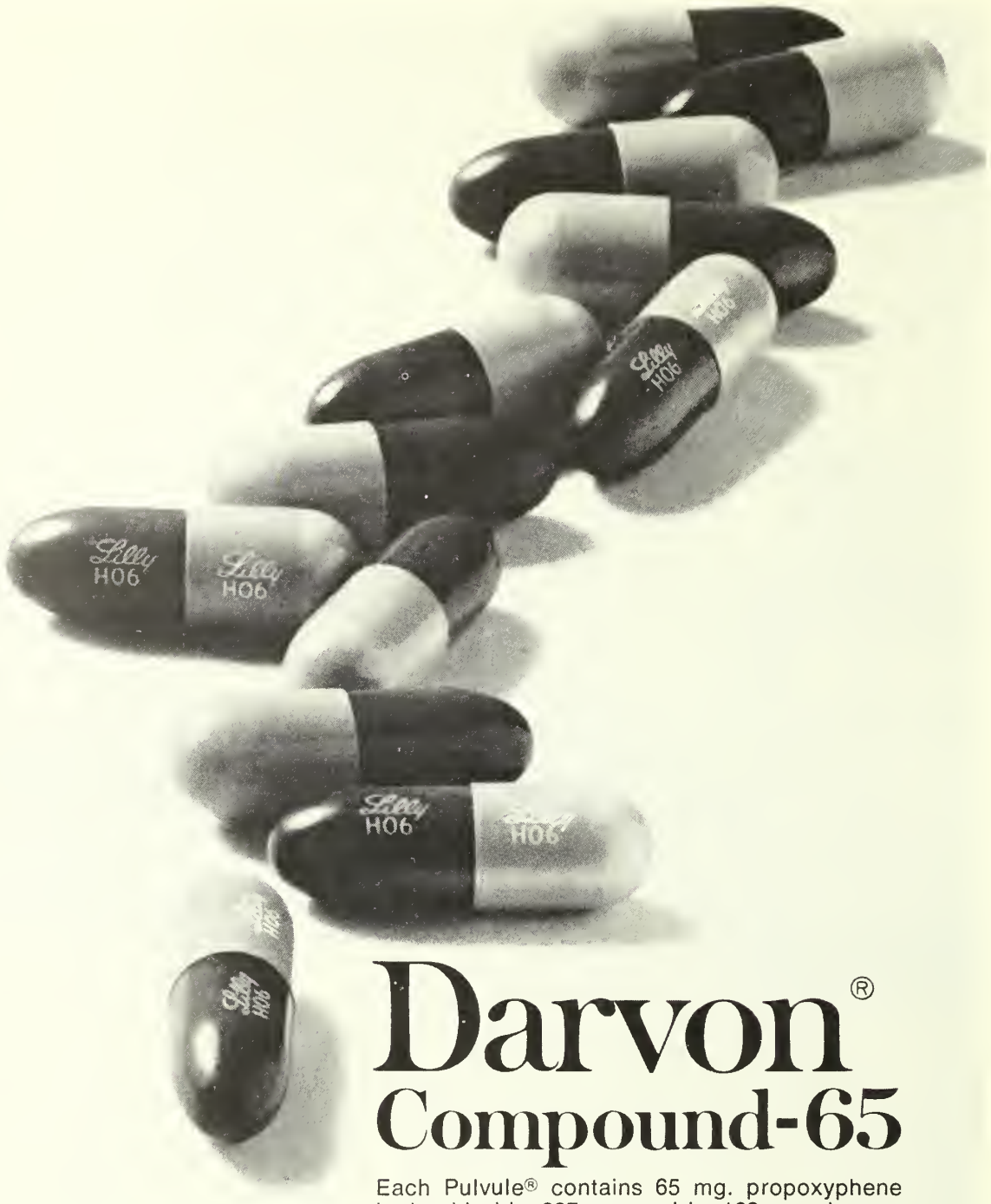

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Preface

Rheumatic Diseases in Industry

GEORGE E. EHRLICH, M.D.
Director, Section of Rheumatology
Albert Einstein Medical Center
Philadelphia

As diseases do not occur in vacuums but in patients, so patients occur in communities. There is no dearth of investigation into the basic mechanisms underlying rheumatic diseases; a glance at the proceedings of recent meetings and post-graduate programs of rheumatism associations and research oriented societies will confirm that we are making inroads on ignorance. Likewise, the past few years have seen the publication of a growing library of books detailing clinical progress. Despite this burgeoning interest, the socio-economic aspects have languished or, rather, reports of undoubted progress in this sphere have rarely beguiled program committees sufficiently to reach the stage of presentation.

A Symposium on the Rheumatic Diseases in Industry encompasses more than the title implies. The total external expression of rheumatic diseases is its subject. The costs alone are staggering, in direct expenditures, unearned incomes, unpaid taxes, and unrealized potential. Better understanding and better management of the problems no longer appear to be the province of the single practitioner. It is no longer sufficient for physicians to diagnose or to dispense nostrums. Partnerships must be developed, not only with other physicians, but with associated health and appropriate lay personnel and agencies. The Canadian Arthritis and Rheumatism Society has created a chain of regional arthritis centers. The Royal National Orthopaedic Hospital in Stanmore, England, favors the team approach, and has pioneered in the development of a rehabilitation officer recruited from labor ranks. Industry and the insurance companies have dealt with the linked problems of re-employment and compensation. The time was obviously right for an exchange of information.

An Introduction

Rheumatic Diseases in Industry

MILDRED C. J. PFEIFFER, M.D., M.P.H.
Harrisburg, Pennsylvania

The following articles are directed to the problem of arthritis in its relationship to industry, employment and professional services. We hope that you will find them a profitable mixture of not only clinical aspects, but some of the other elements that now go into the concept of total patient care.

The articles have been brought about through partnership in a way that was exercised long before the present Comprehensive Health Planning Act, Public Law 89-749, and its emphasis on partnership, was passed. It indicates how much can be done when several agencies work together to produce something that anyone of them cannot produce separately. The articles and their authors are international in scope. This has been the first major effort of its type in the United States. It was executed through the cooperation of the United States Public Health Service, the Pennsylvania Health Department, The Arthritis Foundation —National Headquarters, Central, Eastern and Western Pennsylvania Chapters—the Osteopathic Association, together with the Pennsylvania Medical Society, and at the time of its 1967 Annual Meeting in Philadelphia.

Our objectives in conducting this course and presenting these proceedings are to:

1. present a brief but current didactic review of the rheumatic diseases,
2. explore the economic impact of the arthritis-in-industry problem,
3. evaluate the most frequent rheumatic disease problems encountered in industry,
4. examine the community resources available to aid the physician in developing a comprehensive treatment program.

You, the reader, are indebted to George E. Ehrlich, M.D. Dr. Ehrlich is Director, Section of Rheumatology, Albert Einstein Medical Center, Philadelphia, and a member of the Board of Medical and Scientific Committee of The Arthritis Foundation, Eastern Pennsylvania Chapter. He has generously contributed to the completion of this project by editing the series of papers, discussions and clinics.

Needless to say, the entire program was made possible through many hours of interested effort on the part of each participant and staff member. To them, gratitude is expressed for a rewarding three days, September 28 through 30, 1967, and their contributions to continuing professional education.

Dr. Pfeiffer is Volunteer Medical Director of The Arthritis Foundation, Central Pennsylvania Chapter, and Director, Division of Planning, Pennsylvania Department of Health.

This project of the Central Pennsylvania Chapter of the Arthritis Foundation was under the general direction of Mildred C. J. Pfeiffer, M.D., M.P.H. Additional financial assistance was provided by the Pennsylvania Medical Society and the Arthritis and Diabetes Control Branch, Divisiou of Chronic Disease, Public Health Service, U.S. Department of Health, Education, and Welfare, 1967.

What Arthritis Costs You

ALLAN M. WOLFE, M.D.
Arlington, Virginia

Arthritis is the nation's number one crippler. It costs the U. S. economy almost four billion dollars a year. Approximately thirteen million Americans suffer from arthritis, according to household interview reports. More than ten million have seen a doctor because of the disease. More than three million report arthritis limits their usual activity. About 700,000 are unable to work, keep house, go to school, or engage in most recreational activities.

Among the chronic diseases, arthritis is second only to heart disease in resultant activity limitation. The following annual statistics offer some indication of the problem:

186,000,000 days of restricted activity
57,000,000 days of bed disability
12,000,000 days lost from work

Of the various forms of arthritis, rheumatoid arthritis produces the most crippling and disability. Furthermore, since the onset of rheumatoid arthritis is earlier in life, disability occurs earlier and extends throughout the productive years. Of the thirteen million people who said they had arthritis in the National Health Interview Survey, only five million were more than sixty-five years old. Consequently, the loss in earnings is substantial. Earnings are lost in several ways:

a. Of the 700,000 persons who indicated they were entirely unable to carry on their usual activity due to arthritis, 260,000 should be working if we consider age, sex, employment, and unemployment rates in the rest of our population. The estimated an-

nual wage loss of this group exceeds $1.5 billion.

b. Among the females who are entirely unable to carry on their usual activity and not expected to be part of the labor force, some 224,000 would be homemakers. The estimated cost of their loss of service to the economy, based on $2,670 annually per homemaker, is approximately $600 million a year.

c. Losses exist among those currently employed who lose time each year due to arthritis. The approximated 12,000,000 work loss days occurring each year account for an estimated wage loss of $220 million to arthritics who are currently employed.

d. It is estimated that 28,677 life years and $49 million in earnings are lost annually due to arthritis-caused deaths.

Among the benefits paid to arthritics, the Social Security Administration estimates that $85 million a year is paid to persons with arthritis under the Old Age, Survivors and Disability Insurance Program. The Welfare Administration estimates that $47 million a year is paid to persons with arthritis under Aid to the Permanently and Totally Disabled. Also, the Veterans' Administration pays $261 million per year in compensation and/or pension payments to 330,000 veterans whose major disability is classified as arthritis or rheumatic disease.

The direct medical costs for arthritis are very difficult to estimate. Estimates have been made for the diseases of bones and organs of movement and are some indication of costs for arthritis. (According to the Center for Health Statistics, 67 per cent classified under "diseases of bones and organs of movement" are arthritic.)

Nonprescription drugs, excluding aspirin, account for $435,000,000 annually. Estimates are not available for the costs of prescription drugs, aspirin, physical therapy, certain services in doctor's offices, care in private homes and private insurance benefits. Reviewing these data and the probable magnitude of costs that are not presently estimated, we confidently assume that direct medical costs exceed one billion dollars annually.

Furthermore, the Arthritis Foundation reports that Americans spend $300 million each year for quack remedies and misrepresented drugs and devices (Hyperimmune milk, copper bracelets, vibrators, etc.). Another primary consideration—the costs of the social and emotional problems that result from arthritis—cannot be estimated. However, social problems arise when the arthritic is unable to maintain his usual level of activity on the job and at home.

The following is a list of existing arthritis programs and their costs:

Vocational Rehabilitation Administration	$636,000
Public Health Service	
National Institutes of Arthritis and Metabolic Diseases	8,324,000
Bureau of Disease Prevention & Environmental Control:	
Diabetes and Arthritis Control Program	$905,000
Formula Grants (Federal share)	65,000
Project Grants	155,000
Research Grants	2,400,000
Veterans' Administration In-patients	8,483,000
Arthritis Foundation	$5,416,000
State Formula Grants (State contribution)	64,000
Total	$26,474,000

In summary, therefore, the estimated costs of arthritis are:

Lost work productivity:	
For those unable to work	$1,500,000,000
Lost time from work	220,000,000
Lost homemakers services	600,000,000
Earning lost by premature death	49,000,000
Direct Medical Costs (at least)	1,000,000,000
Quackery	250,000,000
Existing Programs for Arthritics	26,000,000
Total	$3,645,000,000

Special studies of occupational groups indicate high prevalence figures for arthritis. One, conducted by Consolidated Edison Company of New York, discovered all forms of arthritis present among their employees with a high proportion of osteoarthritis incidence.

In Great Britain, studies indicate that the rheumatic diseases account for the largest number of days lost from work—nearly 30,000 days a year.

If we take the rate of rheumatic disability in the United States that is reported on interviews and divide the rate by class of occupation, we discover that most of it is accounted for by white and blue collar workers and very small amounts by service and farm workers. This, at first, seems astounding because we have al-

ways believed that farmers had a higher prevalence of rheumatic disease than others. All it indicates, really, is how statistics can be manipulated. If we were to express the very same data in terms of the population at risk, then we would see what we should have seen before, that farmers have more rheumatic disability per population per 1000 people at risk than any other segment of the population.

Something can be done about arthritis. One of the things that we must do is get people into treatment early. Whether industry and the physicians are capable of doing this remains to be seen. But we do know, and it has been well documented, that the chances of improving are directly related to the duration of disease before the institution of therapy.

Aside from the physical ravages that ensue from arthritis, it causes great economic and social burdens. Gradually, it withdraws from productive activity large numbers of otherwise capable people. Loss of earning power because of crippling leads to economic dependency upon other members of the family or upon community agencies.

Although, at present, there is no cure for arthritis, there is still a serious gap between what is known about this disease and its application in practice. Right now, disability can be arrested, often reversed. That is why the prevention of disability from arthritis must become a priority national commitment.

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How Do Rheumatic Diseases Relate To Economic Potential As Influenced By:

Personal Attitudes and Motivation

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Personal attitudes and motivation exert an important influence on the economic potential of each healthy individual. Vocational counseling is directed at determining some of these factors by means of aptitude, attainment and intelligence tests, interest questionnaires, and eliciting the personal history and educational occupational background from the interview. More recently, vocational counseling has been extended to both the physically and mentally disabled, and this has given rise to a new branch of vocational psychology, generally referred to as rehabilitation counseling. Rehabilitation counseling of the disabled individual presents the counselor with many problems not found in the vocational counseling of the healthy individual. Consequently, the competent rehabilitation counselor must not only acquire the professional skills of the vocational counselor, but should also be familiar with the characteristics of his client's disease.

Vocational rehabilitation of the patient with a rheumatic disease is in many ways different from that of other physically disabled patients, such as the blind, deaf, amputee or paraplegic. Whereas these latter patients possess a physical handicap which is more or less static, the rheumatic patient presents progressive disabilities which may vary from day to day. In general, the chronic arthritis patient suffers from progressive crippling, pain and stiffness; he has periods of acute flare-up of his disease, associated with inflammation, swelling, severe pain and tenderness, marked limitation of motion and general malaise, followed intermittently by periods of general quiescence of symptoms. Consequently, the rehabilitation counselor is faced with a difficult problem, namely should he use the physical condition and disability of the patient during a quiescent period as his base line for vocational counseling, or alternately should he use the patient's limitations during a flare-up of the disease as his base line? Two other possibilities are either to use some kind of arbitrary mean between periods of remission and periods of acute flare-ups or to completely ignore the physical aspects of the disease.

These problems are, of course, directly related to the economic potential of the rheumatic patient and closely concern the central theme of my paper dealing with personal attitude and motivation. I would like to review briefly the present state of knowledge as regards the influence of psychosocial factors on the rheumatic diseases, then discuss some of our own research related to the total rehabilitation of the chronic arthritis patient, and finally suggest a tentative conclusion.

In the 1950's quite a few articles on the so-called "rheumatoid personality" were published, particularly by Ludwig (1952; 1955), Cobb (1959), Mueller and Lefkovits (1956), Cormier and Wittkower (1957), Robinson (1957), and some others. Most of you will be familiar with the description of the so-called "rheumatoid personality" by these various investigators. Very briefly, they concluded that the arthritic patient is intropunitive, meaning that he directs his aggression inwardly, or, as Cobb (ibid.) coined the word, that he displays "contained hostility:" that he has poor identification with the mother, and perceives the mother-figure as less loving and affectionate than the average healthy individual; that the parents were considered strict in discipline, especially the father; and that there was difficulty in sexual identification. Social data indicated the chronic arthritic patient to have a greater incidence of divorce and lower income than healthy controls.

However, already in 1955 King (1955) criticized the earlier studies as singularly lacking in controls. Subsequently, he and Cobb (1958, 1959) carried out new studies with so-called control groups and confirmed previous results by other investigators. More recently, the concept of "rheumatoid personality" and the earlier studies, including those of King and Cobb (ibid.), have been subjected to fairly severe criticism. In particular, Scotch and Geiger (1962) concluded that most of the previous studies do not even meet minimal criteria for scientific merit. Similar criticisms of the earlier studies have been made by Moos (1964). Furthermore, certain hypotheses based on earlier stud-

ies, such as those relating to aggression and maternal deprivation, have *not* been supported by other experimental investigations (Southworth, 1958; Robb and Rose, 1965).

In more recent studies, Moos and Solomon (1964) found that the chronic arthritic patient does evidence certain neurotic behavior patterns. However, these patterns are not apparently specific to rheumatoid arthritis or the rheumatic diseases, but are similar to those found in other psychosomatic diseases or diseases with physical problems. Nalven and O'Brien (1964) also found that women with rheumatoid arthritis obtained a neurotic profile on the Minnesota Multiphasic Personality Inventory (MMPI). However, they did not find any support for Cobb's concept of "contained hostility" in these patients. Williams (1962) also reported that rheumatoid arthritis patients have a different body image than patients with peptic ulcers.

My associate, Mrs. Farr, and I carried out a similar study some years ago, using seventy patients with rheumatoid arthritis and twenty with ankylosing spondylitis. We found that we did not obtain a clear-cut personality picture which could be considered typical of the chronic arthritic patient. The patients' responses to the MMPI yielded many different personality profiles. Most of our patients did not evidence sexual maladjustment and their manifest anxiety approached the normal curve. However, many of the patients did display certain neurotic tendencies, such as depression, hysteria and hypochrondriasis. We also found that our female patients under thirty-nine years of age tended to be more depressed than the older women. Furthermore, the patients with ankylosing spondylitis showed somewhat greater depression and greater bodily overconcern than the rheumatoid arthritics. Our conclusion was that our two patient groups showed some neurotic tendencies, but that these were *not* specific to their diseases.

We have now carried out detailed psychological evaluations of over 300 patients with rheumatoid arthritis and of over 50 patients with ankylosing spondylitis. Although we have found some interesting differences between these two disease groups, it is my opinion that most but not all such differences can be accounted for by sex and age discrepancies. Our recent studies now approximate a cross-section of the total population, from the lowest to the highest socio-economic levels, and including various ethnic groups. Our objective findings show that the arthritic patients tend to differ from healthy normals only in greater signs of neuroticism, particularly depression and anxiety. This result, certainly, does not warrant a specific diagnostic category psychologically, and makes the concept of "rheumatoid personality" meaningless.

We have also observed, that in general, the patient with ankylosing spondylitis has a better work record than the chronic rheumatoid arthritic patient. Furthermore, he tends to be better adjusted to reality, although more emotionally rigid and depressed, than the chronic rheumatoid patient. Yet the patient with juvenile rheumatoid arthritis, of whom we have also examined many, resembles the spondylitic patient in terms of better adjustment to reality and a good work record. Controlling for both sex and age, these differences between the rheumatoid patient on the one hand and the spondylitic and juvenile rheumatoid patient on the other hand are minimized but still apparent.

I would venture to suggest that these psychological and vocational differences are a function of the development of the patient. In general, ankylosing spondylitis and, by definition, juvenile rheumatoid arthritis, attack an individual when he is young and thus more receptive to change and still developing. Consequently, he can maintain a better adjustment to reality than the rheumatoid arthritic patient, as the onset of rheumatoid arthritis is more frequently later in life when personality structure and behavior patterns are more firmly embedded. However, I must stress, that often the juvenile rheumatoid and the spondylitic patient demonstrate more severe and basic personality problems, especially in the psycho-sexual sphere, in spite of their better adjustment to reality, than the rheumatoid arthritic patient.

Finally, I would like to discuss the relation of physical disability in the rheumatic patient to motivation, attitude and economic potential. My colleagues and I are currently engaged in a long-term research project in which we are attempting to isolate factors, be they somatic, psychological or social, which are significantly related to outcome of total rehabilitation of the chronic arthritis patient and which could serve as predictive indices.

Some years ago, Drs. McEwen and Preston and I studied thirty patients, referred for surgery, using psychological tests and the clinical interview. A prediction along a five-point rating scale as to the likely outcome of surgery was made pre-operatively. This prediction was recorded but not disclosed to the rehabilitation team. We found post-operatively that there was in fact a relationship, significant at the 5 per cent level, between the psychological prediction and the actual outcome of surgery.

More recently, Dr. Valery Lanyi has shown in another preliminary study of fifty patients that, out of five factors, namely the joint operated, general health, activity of the rheumatic disease, complications, and cooperation, the patient's cooperation was the most significant factor contributing to outcome of surgery. In fact, cooperation was about the only factor which bore a consistent relationship to outcome of surgery. On the other hand, the activity of the rheumatic disease seemed to be relatively unimportant.

We are just completing another project involving 100 patients, who have had surgery, and our preliminary results suggest once again that the psychological make-up of the patient, particularly cooperation and motivation, are major factors in his post-operative rehabilitation.

In view of these various results we have concluded that motivation and cooperation are the two most significant factors for total rehabilitation of the rheumatic disease patient. The degree of physical disability and the activity of the rheumatic disease, provided it is not in the most acute stage, are relatively unimportant factors. I am not saying that the physical disability or inflamatory processes do not count. Obviously, there are physical limitations imposed on the patient. However, whether or not a patient is able to achieve optimal success from rehabilitation does depend on his psychological make-up. We have seen many patients with minimal physical disabilities, who are unable to hold a job, whereas we also have seen many patients with severe physical disabilities who are holding full-time competitive jobs.

One must realize that the physical disease may serve as an important psychological crutch for the patient. Consequently, one often encounters barriers to supportive psychotherapy and rehabilitation counseling. The pa-

tient feels threatened by the rehabilitative goal if he derives secondary gains from his disability.

In conclusion, we have found at New York University Medical Center that in the majority of rheumatic disease patients a simple improvement in the patient's physical condition is generally not sufficient to ensure return or adjustment to full economic and vocational potential. The patient's personality seems to be the determining factor, especially motivation and cooperation. Thus, we advocate that clinical psychologists, social workers and vocational rehabilitation counselors are necessary members of the rehabilitation team, and that a patient's rehabilitative goal, as determined by the professional staff, must reflect his motivation and cooperation.

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How Do Rheumatic Diseases Relate To Economic Potential As Influenced By:

The Rehabilitation Specialist

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Rheumatic diseases cover a wide spectrum indeed, and the patients' abilities to function or not function, work or not work, vary tremendously. The type of occupation itself may contribute to the rheumatic problem. This can be illustrated by the painful stiff shoulder of the symphony conductor or the painful back syndromes of the Welsh coalminer. Other relatively minor forms of rheumatic disease varying from the stiff necks to carpal tunnel syndromes, impair work capacities in varying degree and time.

It is, however, with the common and hardcore chronic or recurring problems, such as rheumatoid arthritis, ankylosing spondylitis, or severe degenerative arthritis, that the rehabilitation specialist is faced. My comments will deal largely with these problems. We must expend a maximum effort to restore these individuals to work in the home, or the job, or in the school.

In considering this matter, I would emphasize two points:

1. First, the need for appropriate services and personnel which the physician may call upon in managing patients with rheumatic disease.
2. Secondly, the impact that a team approach may have in restoring function and returning individuals to work.

What then is the point of view of the rehabilitation specialist?

As a first line of defense, he would urge the development of adequate community-based social and physical services to prevent unnecessary disability. The International League against Rheumatism, shortly after World War I, recognized this need in their motto, "Every disease with a social significance should be fought at the beginning and not at the end."

The individual with a recurring long-term non-lethal disease, such as rheumatoid arthritis, if neglected, may become so conditioned to disability that even when physical disability may lend itself to correction, rehabilitation with its economic benefits may become impossible.

In addition to physicians and the hospitals in which they work, there is an important need then in all communities for basic services, some of which are indicated in Table I. To be most effective in the care of rheumatic disease, the paramedical personnel involved should have special orientation and experience in the care of rheumatic disease. The services should be available to the physician for his patient at all levels of care, including home.

The Problem

Since ability to work is related largely to functional capacity, and to a lesser degree, age, the pattern of disability in rheumatoid arthritis is relevant to our discussion.

Tables II and III illustrate the age group and functional status of 10,000 consecutive Canadian patients with rheumatoid arthritis referred to Canadian Arthritis Society physiotherapists.

TABLE I
BASIC COMMUNITY SERVICE

Social Services
Physiotherapy and occupational therapy (with appropriate facilities)
Vocational guidance and placement services
Workshops (larger communities)

TABLE II

FUNCTIONAL CLASSIFICATION 10,076 PATIENTS WITH RHEUMATOID ARTHRITIS USING C.A.R.S. FIELD FUNCTIONAL CLASSIFICATION

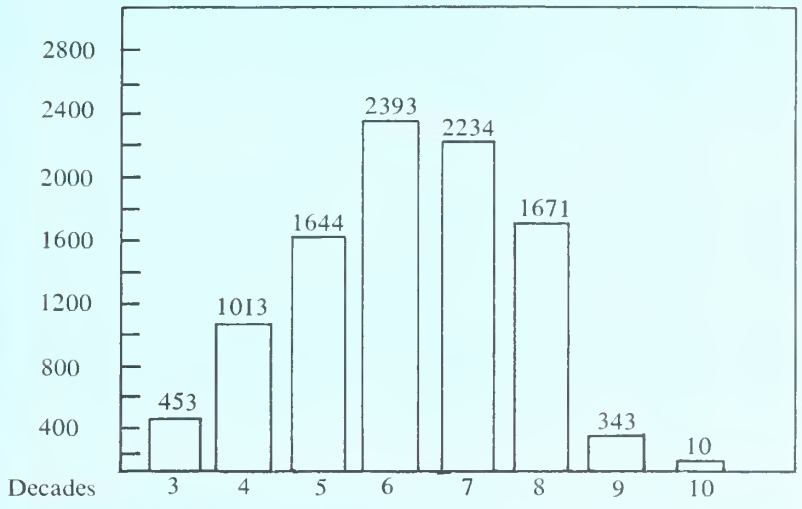


Table II indicates the age of referred patients in decades. Four hundred fifty-three were in the third decade of life, 1,013 in the fourth and so on. Rheumatoid arthritis patients can look forward to a normal expectancy of life; therefore, the rheumatoid patients with disease onset in the third decade are added to those developing the disease in the fourth decade and so on; the numbers in each decade are cumulative. Most patients are in working years of life with largest cumulation of patients in the sixth and seventh decades.

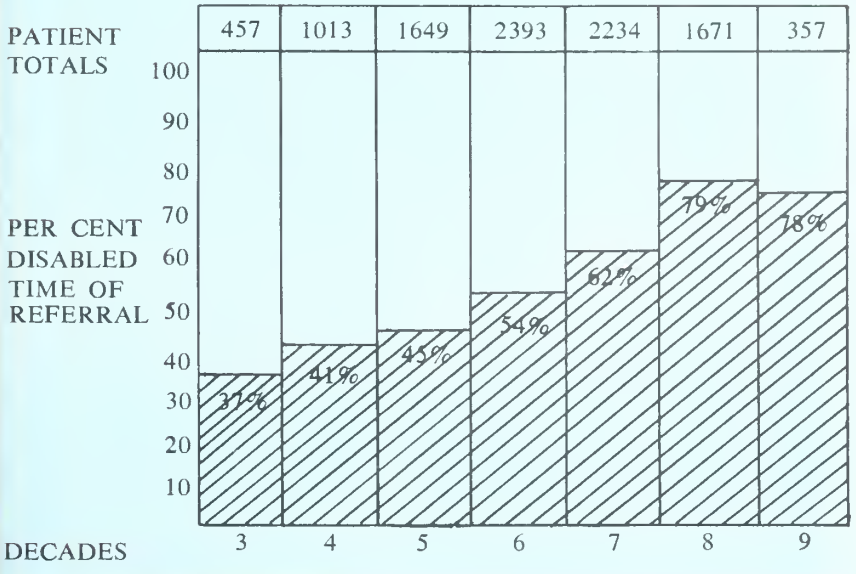
When a physiotherapist first sees a referred rheumatoid patient, the patient is put into one of four functional classes. Class I patients are functioning well. Class IV patients are very severely disabled and Class II and III patients fall between these extremes. For simplification, patients are catagorized in Table III as either disabled or not disabled.

This chart from left to right is divided into decades of life. In each decade the striated area indicates the percentage of patients in that age group disabled at the time of referral. With increasing age, there is a cumulation of disability. In the third decade, approximately one-third are disabled compared to two-thirds disability in those in the seventh decade. The increased disability reflects in part the greater proportion of patients who have had the disease for a more prolonged time.

This then is representative of the reservoir of people in our communities disabled with one disease, rheumatoid arthritis. Adequate preventative and restorative services can significantly affect this picture.

TABLE III

DECADES OF FUNCTIONAL DISABILITY FROM RHEUMATOID ARTHRITIS



Arthritis Unit

A second current concept is that of the rheumatic disease unit. This is a specialized in-patient care unit for the team treatment of arthritis. In addition to treatment, these units serve educational and research aims and lead to better care. They are usually situated near or as part of major teaching centres. There are currently several such units in Canada and it is from the context of such a unit in Vancouver that my subsequent remarks are made.

Vancouver Arthritis Unit

In B.C., the patient with serious rheumatic problems requiring evaluation, education and treatment is referred to our rheumatic disease unit by the physician. The case load includes the patient with continuing disease threatened with continuing loss of ability to work as well as the already disabled patient. While in some patients the treatment goal may be return to work, other patients will be seriously disabled individuals where a realistic goal may only be return to personal self-sufficiency. Several hundred patients have passed through this Unit in the past few years.

In the Unit, a team of individuals including physicians, social workers,

occupational therapists, physiotherapists and nurse, evaluate the physical and social aspects of the illness.

The rheumatoid patient is assessed as to the degree of activity of the systemic disease (which may or may not be active) and as to the physical impact the disease has had on him. His social functioning is evaluated and finally, by a series of test situations, his ability to function physically is assessed.

Over a period of two to three months, general medical management of the disease is carried out. Patients are trained in the conservation of damaged points. As many functional problems as possible are overcome using restorative therapy—and where functional deficits cannot be overcome, the use of bracing devices or surgical procedures may allow improved functional capacity. Social workers promote maximum personal, social and vocational functioning, using community resources for testing work aptitude, retraining and job placement as required. The occupational therapists visit the home or work area and adapt this as necessary for maximum function.

Functional Capacity

In testing functional capacity in a patient we compare his capacity to a series of standards we call a minimum normal function.

In order to work at an average job, a person should be functionally able to manage all self-care in a reasonable time, use stairs and also be able to use private, or even public, transportation. Finally, he should have enough activity tolerance to manage throughout the eight-hour day.

In this unit, each patient is evaluated by a series of functional tests at admission and discharge.

Table IV illustrates the change in functional status in one individual followed in such a centre over a three-month period. In this particular patient there is improvement in these four parameters of functions, self-care, ambulation, transport and activity tolerance. The results are expressed in percentages of minimum normal function.

Because functional capacity and workability are so closely related, it is of interest to see the results of evaluation of functional status in a sample of sixty-two patients tested in this way before and after treatment.

TABLE IV
FUNCTIONAL PROFILE

	Initial 17 March	*Discharge 15 June*
Self Care	92%	99%
Ambulation	51%	78%
Transport	50%	100%
Activity Tolerance	40%	75%
Function	58%	88%

These are screened patients who, we believe, are well motivated.

The average age of these sixty-two individuals was forty-nine. Two-thirds were women and one-third, men. They spent an average 2.8 months in the Arthritis Unit. In all of these patients, at the time of admission, function was reduced to less than 80 per cent of "minimum normal function."

The results of treatment in terms of functional change in these patients is indicatded in Table V. As is indicated by this table, there was no significant change, or worsening in twelve (or 20 per cent) of the patients with rheumatoid arthritis.

TABLE V
FUNCTIONAL CHANGE—62 PATIENTS
Initial score <80% minimum "normal" function.

Worsened or insignificant improvement	12
Improved 5%-24%	28
Improved 25%-44%	22
Total	62

A word about the unimproved group. Rheumatoid arthritis, being a fragile disease with unpredictable flare-ups, may, of course, worsen despite our best efforts and at times we may be left fighting a rearguard action. In the fifty remaining patients, there were very significant gains in function during the period of treatment.

If we break down the functional areas into ADL or self care; ambulation; ability to use transport; and activity tolerance (Table VI), of these sixty-two patients it can be seen that forty-three patients improved in activities of daily living, forty-two in ambulation and thirty-three in activity tolerance. In twenty-four, or in less than half, it was possible to improve ability to use transport. This was largely due to difficulty of many patients in using public transport such as buses.

Return To Work

Several years ago we did a study attempting to find out what impact such a team approach had on the earning power of individuals subjected to it—with a two-year follow-up study. There were forty-six men with rheumatoid arthritis or ankylosing spondylitis admitted consecutively. Ten of these were severely disabled individuals admitted with a goal of improving self-care only. These were not included in the analysis. Two were lost to follow-up. The remaining thirty-four men had a change in work capability as seen in Table VII.

At the time of admission, five were still managing to work at full-time employment by virtue of understanding employers. None were working part-time, three were working intermittently and twenty-six were unable

TABLE VI
TOTAL 62

	Self Care	*Ambulation*	*Transport*	*Activity Tolerance*
Improved—	43	42	24	33
Worsened—	4	4	3	2
Unchanged—	15	16	32	27

to work. By two years after discharge, nineteen had returned to full-time work, eight to part-time, none were working intermittently, and seven were unable to work.

The work history is of interest. The majority, nineteen, were individuals who had worked at heavy labour in farming, fishing and lumbering industries. Seven had trades, four were white collar workers and four did miscellaneous light jobs. Of the thirty-four men, five were given re-training, seven returned to the heavy labour market because of lack of job opportunity elsewhere. The remainder returned to their trades or took light categories of work which they were able to find. Seven were still unemployed at the end of two years for various reasons, including flare-ups in disease.

TABLE VII
EMPLOYMENT STATUS
34 MEN

	Date of Admission	*Two years after discharge*
Full Time	5	19
Part Time	—	8
Intermittent	3	—
No Work	26	7

The economic picture is of interest (Table VIII). Over the ensuing two years after discharge, there were very significant increased earnings over and above the pretreatment year. This amounted to a total of $42,322.

TABLE VIII
EARNINGS
34 MEN

Pretreatment year	First year after discharge	Second year after discharge
$19,943.00	$32,322	$49,961
	Increased earnings $42,322	

It seems, therefore, that we significantly improve the functional status of patients in such an arthritis unit, and that this can be measured in economic terms.

Before concluding, I would like to emphasize the increasing role the orthopaedic surgeon is taking as a member of the rehabilitation team in contributing to both preventative and restorative aspects of treatment. This is a development which has accelerated over the past six or seven years. In our Unit, a close co-operative relationship has developed between the Department of Orthopaedic Surgery of the Medical School and the rheumatologists in the Arthritis Unit. The close integration of the rehabilitation program before and after surgery has proved to be most important in this development. Currently about one of three patients admitted to the Vancouver Arthritis Unit is subjected to surgery ranging from synovectomy or arthroplasty of the knee joint, to correction of the deformed rheumatoid hand, or excision of painful metatarsal heads in the feet.

Increasingly, the attention of the physician involved in rehabilitation today must be directed towards sharpening his ability to evaluate function and promote sound follow-up studies of the many current surgical procedures.

To Sum Up

I have emphasized the importance of making available adequate preventative services for the physician in the community, and have outlined how the specialized rheumatic unit may employ the team approach to improve function, work capabilities, and therefore provide greater economic opportunity for the arthritis patient.

Dr. Robinson is Medical Director, Canadian Arthritis and Rheumatism Society, Medical Centre, British Columbia Division.

What do you give the guy who has nothing?

You get him off to a good start.
With U.S. Savings Bonds.
On his first birthday.
On his first Christmas.
As he grows, the Bonds grow.
When he's ready for college, the Bonds can help put him through.
And if everybody in the family gave him Savings Bonds, someday he'd be a very tough guy to buy anything for.
Because what can you give a guy who has everything?

GIVE U.S. SAVINGS BONDS

How Do Rheumatic Diseases Relate To Economic Potential As Influenced By:

The Physician

DERRICK A. BREWERTON, M.D., M.R.C.P., London, England

Although we are discussing all rheumatic disorders, I think I can make my meaning clearer by confining my remarks to two problems in rheumatoid arthritis: early and late in the disease.

Any patient who has recently developed rheumatoid arthritis inevitably thinks often about the future. Perhaps you can imagine your own feelings under these circumstances. Predominantly, a woman worries about her capacity to look after her family, and a man worries that he may not be able to earn his living. He is terrified by thoughts of prolonged unemployment and his family being dragged gradually towards poverty. He can accept the diagnosis, usually he can accept the thought of chronic pain and even deformity, if only he can be reassured about work. Given a choice between pain and a job, most patients would choose the job. We physicians must remember this when we survey our results: if the patient remains unemployed, we have failed; and sometimes we must admit that we have failed because we were too interested in the medical problems and not in the patient.

Perhaps some physicians do not appreciate why they must become involved in vocational resettlement with some diseases and not with others. A surgeon looking after a young man who has recently lost his hand in an accident can pass the resettlement problem to someone else with everything explained in a letter. The implications are obvious, and without any interpretation from the surgeon, everyone, including the employer, will understand what has happened and what the man will be able to do. By contrast, only the physician responsible will understand fully the patient who has recently acquired rheumatiod arthritis. He will have investigated him thoroughly and examined every bone, joint and tendon, leading to a complex assessment based on a lifetime of experience of arthritis and arthritics. No one else can do this; the vocational counsellor can't do it; the employer can't do it; and unless the physician passes on his knowledge in some detail and is prepared to discuss what should be done, all the people concerned with the man's re-employment are lost and unable to make decisions. This is true of all diseases or disabilities which are complicated to assess and to understand, and are variable with a prognosis which is difficult to predict. It applies to most rheumatic disorders: whether it is sciatica, brachial neuropathy, shoulder capsulitis or osteoarthrosis of the hip, the clinician must be the key figure in helping the patient back to work. He cannot make a simple paper transferal to someone else. Rehabilitation must never become something separate from the rest of medicine allowing us to send all our employment problems elsewhere so that we can concentrate on our medical interests. The essence of good rehabilitation is in the everyday management of common medical problems and every clinician must take a lively interest in the rehabilitation of his own patients. The neurologist must be interested in the employment of epileptics; the orthopaedist, hand injuries; the psychiatrist, alcoholics; and the rheumatologist, arthritics.

The physician treating early arthritis must understand his patient, his hopes and fears, his home and family background, and, of course, details of his work. In this latter respect, I am very fortunate in having a rehabilitation officer, Mr. J. W. Daniel, who will visit the place of work, discuss the problem with all concerned, and report back to me with all the information I can possibly need to reach a decision. I like to think that he has taught me a lot over the years and particularly by his follow-up visits to see how the patients are actually managing under conditions of employment.

No patient can plan his future without understanding his disease and what it is going to mean to him. This is one of the physician's important responsibilities: to be honest with his patient and discuss frankly the disease and its problems. There is no excuse for being secretive; this isn't malignant disease and usually the patient has been imagining the situation to be much worse than it is. Discussions about work should begin at an early stage and should not be delayed until the patient is almost fit to return to work. From the onset his mind will be seething with thoughts about work and he needs to discuss them. He will be encouraged that his physician takes an immediate interest in when he will return to work, even when he is ill and despairing of his own future.

The employer should be brought into the picture at an early stage. It helps to do this while the trail is warm and everyone remembers the patient well, and before his job is given to someone else. The employer who is asked to re-employ an arthritic patient is often placed in a difficult position because he is not given sufficient explanation or reliable information to allow him to assess whether he is taking an unreasonable risk. Directly or indirectly, this advice must come from the physician because he is the only person who knows how much the patient could be expected to do, and whether there is likely to be much fluctuation in the severity of the disease. We also have a general responsibility to help all employers to understand this problem better; and presumably this is one of the more important reasons for this symposium. Like most lay people many employers imagine that patients with rheumatoid arthritis usually get steadily worse and end up in wheelchairs. They do not know that the disease often settles almost completely, or remains very mild from the onset. In England, Kellgren and his colleagues showed in a field survey in 1953 that of men with rheumatoid arthritis, 80 per cent had lost less than three months of work in a five-year period, and 50 per cent had lost no time at all in five years—much better than many normal people. These figures could undoubtedly be improved with much effort. In the States, this

would represent over one million men with rheumatoid arthritis in regular employment—say 20,000 in Philadelphia.

Early in the disease the choice of job is usually not a major problem because the first object is to get the man back to his old job or at least with his old employer. This involves starting early, keeping the employer fully informed and making a determined effort to overcome all the practical problems. We feel strongly that it is no good sitting in hospitals writing letters to people: somebody briefed by the physician must go out and look at the job and discuss it on site, and that person must have been trained in industry and speak the language of industry. We don't readily admit that we cannot get a man back to his original employer, but if this is the case, work must be sought elsewhere, doing a job which is known to be available in the district and which is related to his old job so that he can use his skill and experience to the best advantage. Naturally it is important to make allowances for fluctuations in the disease and any tendency to fatigue. If a patient is pushed too close to the limits of his capacity, he is more likely to be off work every time his disease is a little worse. At this early stage, we don't find it necessary to use elaborate systems of vocational testing, but we do assess some patients in the workshops of the Occupational Therapy Department, mainly to see their capacities to do a day's work.

Later in the disease, we meet an entirely different problem: the man who has been unemployed for a long time due to illness, pain or neglect. It may be that this was inevitable while his disease was active and that now his joints are less painful, he does not know where to start. It is here that we need all the facilities which go under the heading of rehabilitation. I must admit that even here we have not often used formal psychological testing but have tended to rely more on reports from our occupational therapists and teachers. In the workshops of the Occupational Therapy Department there is a work atmosphere and patients do a full day's work, simulating as closely as possible their future employment. This gives us information not only on the patient's capacity to work, but also whether he is punctual, can take orders, concentrate on his work, show initiative and above all, whether he really wants to work. At Stanmore, we are exceptionally lucky in having an excellent section of Adult Education for patients admitted to the wards. We have always had a big school for children, but for the past fifteen years, we have had regular adult education for about thirty-five patients at any one time. This is provided by two full-time teachers and several part-time teachers, including research workers from a nearby factory who give voluntary help with technical subjects. This means that a man who is admitted for a prolonged period can have an early decision on future employment followed by intensive, suitable education. Often this education is more important in getting him re-employed than any physical improvement. As an example, we recently had a labourer from a laundry who had developed a tuberculous spine and was going to be unable to do the lifting involved. Fortunately, we discovered that he was an intelligent man who had had insufficient education. While his back was being treated, he was taught enough to send him back as foreman to the same laundry.

There is nothing more demoralizing than to have chronic pain and be out of work. It is small wonder that rheumatoid patients in this situation queue up for treatments of all kinds. But get them back to work, give them their pay and their self-respect, and they will lose interest in their physiotherapy and their pills. Work is undoubtedly the best analgaesic.

Doctor Brewerton is Consultant Physician in Physical Medicine to the Westminster Hospital and the Royal National Orthopaedic Hospital.

How Do Rheumatic Diseases Relate To Economic Potential As Influenced By:

Labor

MR. J. W. DANIEL
London, England

The majority of patients in hospitals are worried about their jobs. It frequently happens, however, that medical treatment is handicapped because a patient is not at all clear about its effect on his future wage-earning capacity.

The fact that his doctor discusses his future in general terms, is neither helpful, nor very convincing to him. For although he is prepared to acknowledge without argument the doctor's clinical skill, he places little reliances on medical opinions as to his future capacity to work.

There's no reason, really, why he should; such an estimate requires an accurate knowledge of the physical demands of that work, and, after all, it is the patient himself who has to balance physical suffering on the one hand against income. Bad working conditions against interest in the work, boredom and frustration in a dull job against the ease with which he can perform the task.

He considers the doctors have had little opportunity for acquiring such knowledge. I think the vague expression, fit for light work only, so frequently seen on our medical certificates, fully justifies his opinion.

I know these observations are fully endorsed by Dr. Brewerton. Medical training makes no provision for the opportunity to understand these fundamental details. Equally, I have had no training in medicine. My background is industrial. Consequently, we work in close consultation for the purpose of providing a cohesive objective program of rehabilitation for our patients.

At the National Orthopaedic Hospital, it is normal practice to start practical plans for the patients' resettlement as soon as possible after admission. The two Rehabilitation Officers employed by the hospital provide this very important direct link between the hospital and industry. We spend 50 to 60 per cent of our time in industry, on the shop floor, working closely with management unions. The remainder of our time is spent in the hospital, attending ward rounds, clinics, and conferring

The motor mechanic *must (top to bottom, left to right) 1. stretch, 2. bend, 3. work in confined spaces, 4. use the full power grip, 5. use the fine, pinch, or precision grip and 6. be muscularly strong.*

with patients, doctors, and the rest of the rehabilitation team.

The cases that are referred to us, are those patients whose prognoses indicate the possibility of residual disability which might adversely affect their future employment. The method we employ is as follows: on receipt of a referral, the patient will be interviewed in the ward. On this initial interview, there is a very good chance that we will know something about the firm he works for. We will most certainly know something about the machine he works on. We will probably know not only his shop foreman, but also his shop steward.

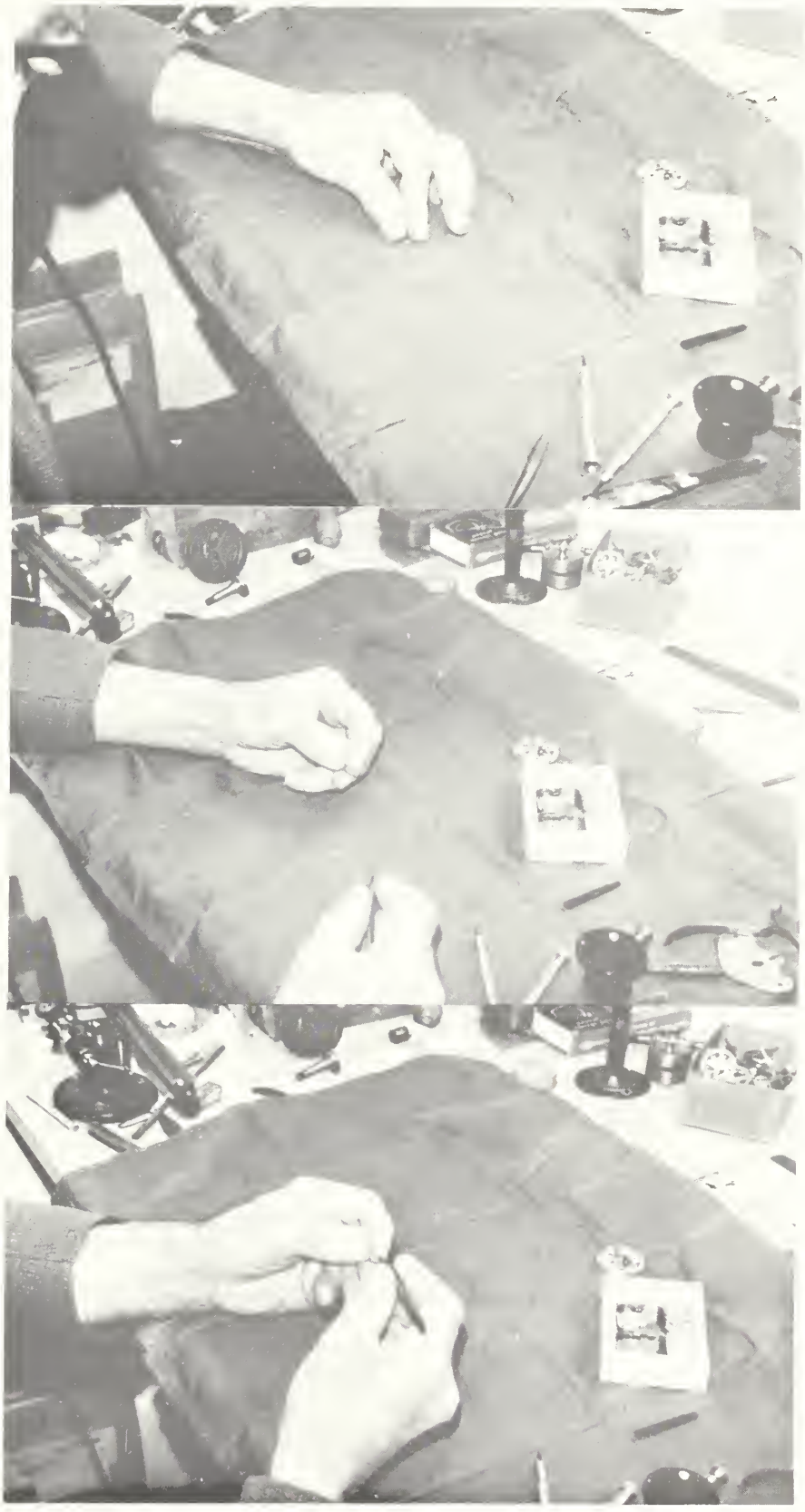
At this early stage of treatment, therefore, the patient is being given the opportunity to make a clearer and much more positive assessment of his own future working prospects. He is also able to gain some confidence from the fact that his future is, perhaps, not quite as bad as he has originally envisaged. He is, in fact, being provided with the stimulus to cooperate with treatment. It follows that, as his future becomes more assured, he gets more incentive to return to work.

Following this interview, we go to his place of employment, and we will do this as a representative of the hospital to place our combined knowledge at the disposal of the management for the purpose of getting their employee back to full wage-earning capacity. Remember, this interview is taking place very soon after admission, so we are in a position to offer to help with the problems of *their* employee. We are not applying for assistance in placing *our* patient.

At this first visit, we will make what is virtually a time and motion study of the job: height of benches, position of handles, the amount of floor space that has to be travelled, width of doorways if he is going to be a wheel-chair patient, any of this, and then report our findings back to the rehabilitation team.

The accompanying photographs show a cross section of industrial job activities by function.

The illustrations on page 76 are of a motor mechanic. You will note he is required to stretch, bend and work in confined and difficult positions. He needs a lot of muscular strength. His manual activities encompass a complete range of functions from the power grip at one end to the fine



The watch and clock repairman *uses the master hand for his tools and his opposite hand becomes his vice. The vice hand (upper photo) approaches the work with the permanent pinch maintained between the thumb and index. He lifts (center) the work in one movement, and presents it to the master hand (lower) by the most economic route.*

pinch grip at the other.

Watch-clock repairing and jewelry making, illustrated on page 77, are two examples of sedentary work in which good eyesight is essential. From the perspective of hand function, this type of operator uses his master hand to hold the tools of his trade, while the second hand becomes his vice. With this hand, he instinctively makes a pinch grip which he retains throughout the work period.

Therefore, dysfunction of the thumb of the second hand, or a loss of that tip of the thumb, can be a serious impediment to this type of worker.

We are all familiar with the work of carpenters and joiners. You will note from the accompanying photographs, should our patients have a disability affecting the hands, more detailed information describing the hand functions of the particular job is obtained. With the provision of this information, it can be decided early in the stage of treatment whether the patient will be capable of returning to his former job. If medical opinion suggest that this is possible, then the Physical Medicine staff has a good goal toward which it can work, and treatment will be related to functions for the job.

For those patients considered physically incapable of returning to their former work, further investigations will be made, preferably with the original employer to find alternative work, and to ascertain the standards required.

The rehabilitation program will then be modified to include either an education, a work sample or a re-training program according to the specific need. The following two cases illustrate these points:

The first young man first attended our hospital just over eight years ago with a painful, swollen knee. He was referred to Dr. Brewerton, who diagnosed early stage rheumatoid arthritis. I was advised in detail of the course the disease could be expected to take, and instructed to make suitable provision for this eventuality. He was a fifth year apprentice monotype caster operator in the printing trade. The castings he would be required to lift would weigh in the range of 9 lbs. to 56 lbs. These castings are stacked from floor to ceiling, so his job would involve standing, lifting, bending, climbing ladders, everything, in fact, which was going to be beyond his physical capabilities.

The obvious occupation for this young man, within his own trade, would be that of monotype keyboard operator. This is a full-time sedentary job. My first investigation produced two problems: first, the firm carried no keyboard work; secondly, as a member of the Monotype Casters Union which operates only in London, he would never be permitted to undertake a keyboard with his current union card.

To overcome those difficulties, three things had to be done:

1. Obtain the appropriate union card
2. Obtain a course of training in keyboard work
3. Find him a job

As a result of the close contact that we have been able to build up, both with the union and employers over the years, all of these were achieved while the patient was still under treatment in the hospital. Within two weeks the appropriate union card for the National Graphic Association was obtained. Within thirty days he had been enrolled for a three-month course in keyboard operation and had a promise of a job at the completion of his training.

He has been with this same firm now for the past seven and a half years. In the first two and a half years of work, he lost eighty-two days due to his disability. Again, Dr. Brewerton had advised me that this sort of thing was likely to happen. I therefore had been able to make provision for it.

Every time he was away from work for three days or more, the union found a temporary replacement for him. I had organized this with the union and with the firm. Eighty-two days in two and a half years sounds a lot, but I prefer to look, not at the time he was away from work, but at the time he was at work.

Two and a half years on a five-day working week is 650 days. This means that during the active early stage of his illness, he spent 568 days on productive work. This is the way I look at it. You may rest assured this is the way the firm looks at it.

In the last five years, he has never had a day off from work. He is paid top wages. He is married, has two children, and is buying his own house.

The second case, I think, underlines all the points to which Dr. Brewerton made reference, particularly with regard to paper transferals. This is a man who had been employed for fourteen years as a Security Guard with an aircraft industry. His work involved two hourly patrols. At fifty-two years of age, he had rheumatoid arthritis affecting his ankles, shoulders, elbows, and hands. He saw his own doctor who referred him by letter to a local hospital. He was advised there to give up his job, which he did. He was referred by a Ministry prescription from a Vocational Rehabilitation Unit where he was assessed as unfit for normal open employment and was sent to a sheltered workshop for three days a week.

This was the situation when he was finally referred to our hospital some four years later. From the way Dr. Brewerton reacted to what he considered gross mismanagement of a relatively simple case, I imagine the original medical notes must have been written on asbestos.

The patient was told quite clearly that his disease would burn itself out within the next three to four years. He was informed of my professional role and that he should make plans to get back to normal employment of a sedentary nature.

The rest was relatively simple. He went back to his original firm, the aircraft industry, as a dispatch clerk. When he first returned to work, it was as much as he could do to hold a pen. The firm was considerate in the early days of the patient's return to the job. He has been back at work now for four years. He is now a relatively normal man in a normal job, who tells me that he walks three quarters of a mile to work just for the exercise.

In conclusion, our aim is to discharge our patients to conditions where they can enjoy the greatest possible measure of good health, and at the same time, attain or pass their accustomed standard of living.

If we are to achieve this aim, we must appreciate that the need for personal contact and continuity in the work of rehabilitation is of paramount importance. I have already spoken about the personal contact side of our work. I would just like to conclude with a few words on continuity.

Once our patients have been discharged back to work, regular follow-up visits are made to the firm in the early stages of resettlement, to insure that everything is proceeding according to plan. This is good public relations work which is essential to consolidate not only the working conditions for this man, but also to estab-

lish good contact for our future patients.

Apart from the regular visit to the firm, every one of our patients are followed up for a minimum period of five years. In the cases of unstable disabilities, I follow up indefinitely.

The information that I receive in the follow-up replies is distributed to the various departments of the hospital as a matter of routine. As a result of this, slight recurrances of complaints which might have otherwise gone unreported, social or domestic problems, probably arising from the disability, or difficulties in adjusting to industrial conditions, are brought to the attention of the department concerned, and the matter can be dealt with with due expediency.

Finally, we feel that this type rehabilitation service from the hospital offers many advantages. I've listed five which I consider the most important.

First, the patient is encouraged right from the start of treatment, to take an optimistic view of his future as a wage earner.

Secondly, employers are encouraged to keep jobs open for the patients.

Thirdly, any modifications or alteration to the job can be carried out while the patient is in the hospital under treatment, thus avoiding any delay after discharge.

Fourthly, by returning to his own place of employment, he has been provided with the idea of going back to full wage-earning capacity.

Finally, the time spent off work drawing social security benefits is cut to the minimum.

Mr. Daniel is the Hospital Rehabilitation Officer at the Royal National Orthopedic Hospital.

How Do Rheumatic Diseases Relate To Economic Potential As Influenced By:

The Insurance Carriers

MR. CHARLES A. PLUMBER
New York, N. Y.

Life insurance had its origin well over a hundred years ago, but group life insurance was heralded with entree until shortly after the turn of this century. The advent of group life insurance was heralded with skepticism by some and held as incredible by others. However, during the fifty-year period following the date the first group life contract was issued in excess of 100, billions of group life insurance have been written. This was almost five times the individual life and ten times the industrial type life issued during the same period.

This outstanding reaction is mentioned simply to demonstrate the tremendous public acceptance given to this new concept as well as the remarkable degree of acceptance that has prevailed to this date.

Also, it is an important backdrop for points that will be made later on.

It was but a brief period before group accidental death and dismemberment benefits were provided. Then in 1920, less than ten years after the first formal group life contract was issued, the first significant step was undertaken to provide group insurance benefits in the area of health in general. In that year group accident and sickness policies providing loss-of-time benefits were first issued. In regular progression group insurance was expanded to provide still further health insurance benefits.

Group hospital and surgical expense benefits were first provided in 1928.

In 1940 medical expense benefits were provided.

In 1954 major medical expense benefits were provided.

In 1959 dental expense benefits were provided.

During the same interval and to this very date the portfolio of group coverages is being expanded to provide even greater, more diversified, as well as more comprehensive benefits, in all areas of health insurance.

We are talking about achievements during a period of less than sixty years, and, particularly, during the short period that health benefits have been made available, the growth in group health insurance has been phenomenal, particularly since World War II. It may be argued that such growth has been too moderate and has not kept pace with human and social requirements. However, during the last twenty-five years the great changes in medical, hospital and surgical care with the attendant escalation in cost factors has put challenges and certain areas of concern before the insurance industry. The insurance industry as a whole has achieved an outstanding record and reputation for careful projection of risk, thorough analytical and statistical surveys, skillful under-writing and prudence in financial responsibilities which has resulted in a stability that is unmatched and a record of high risk persistency so important to the success of insurance enterprises of any kind. Such safeguards have, perhaps, tended to curtail certain advances that might have been made. It would seem appropriate to mention a few vital and pertinent statistics before I proceed the real subject matter.

As of this hour over 85 per cent of the civilian population of this country, approximately four out of every five persons, have some form of health insurance through voluntary insuring organizations. *We are talking about 170 million Americans.* It might be of interest to observe that as of this hour the population of this country is over 200 million, and will increase by approximately 750 during a three-hour period!*

According to the latest available information, it is indicated that upwards of 113 million persons have regular medical expense protection; approximately 52 million persons have major medical expense policies; over 146 million persons have surgical expense protection, and almost 52 million persons have protection against loss of income due to disability. These same high levels of protection prevail with respect to the many other health insurance coverages.

We are concerned more with the economic potential involving rheumatic diseases. In giving an insurance

* Demographic data provided by Dr. John Reilly, Vice-President and Social Research Director, Equitable Life Assurance Society.

company's point of view and to be fully expressive, I will combine all disabling-type diseases in general. Regardless, the insurance industry from its beginning, and particularly with the advent of group insurance, has been in the main stream of the national, local and family economy and has wielded a strong influence thereon. This is manifestly true during the last thirty-five to forty years when group loss of time, hospital, surgical and medical benefits have been provided and accorded such outstanding recognition and receptively. The availability of these benefits provided at low cost due to the grouping process serves to defray in full or in part those costs incurred due to required medical, hospital or surgical treatment, as well as loss of time, in the event of total disability. Indeed, these benefits are a definite therapy, both mental and physical as well.

Let us take a person afflicted with rheumatic disease and let us assume that the person has reached a total disabling stage, although not necessarily permanent, and is confined to a hospital. This person is confronted with loss of income, medical expense, as well as hospital and other extraneous expenses. If that person is blessed with insurance benefits to defray all or a major part of the expenses, then most certainly an important and beneficial mental therapeutic reaction must take place. It would then seem to extend to a physical therapy as well.

However, while this simple illustration portrays the therapeutic values, it does at the same time reveal the economic value to the person. I can even extend to the economy of the community and its social services if the person would otherwise be dependent on such services. It would seem that any instrumentality that can function in any way to curtail continuing exposure to medical and hospital care and advance the date when occupational and vocational activities can begin or be reinstated is a definite economic factor. The economic potential as it may concern the individual afflicted with rheumatoid arthritis or any other affliction is most definitely involved with the future of private insurance. As I have already stated, health insurance is well established and has been accorded remarkable receptivity. However, it is recognized by all responsible insurance companies that they have an obligation, in fact a responsibility, a perpetuate health insurance for the public, especially for persons who are under age sixty-five. It will be necessary to develop new concepts of coverage, to explore new methods of marketing and, particularly, to find methods of providing benefits to persons who are now ineligible because of underwriting limitations and restrictions, as well as restraints that are imposed by the regulatory bodies of the various states.

In short, the insurance industry is faced with a call to action and an opportunity, as well as a challenge, to reconstruct and move forward to even greater achievement than that which has already been so magnificently recorded.

Therefore, in order to preserve the philosophy, acceptance and practice of health insurance and to maintain the powerful and far-reaching economic factors that are a natural yield, I would like to cite some of the undertakings that confront the insurance companies and which I feel sure that they are prepared to embrace:

1. A tremendous effort to extend health insurance to persons not now insured, are under-issued or are not now eligible.
2. To find new methods of getting the message as regards the need for adequate health coverage across to the public.
3. To find new methods of marketing and improved devices to assist in fulfilling the needs of the public.
4. To minimize and eliminate where possible underwriting restrictions and contract limitations and exclusions.
5. To enter discussions with state regulatory bodies regarding certain restraints.
6. The employment and careful training of pertinent manpower.
7. The promotion of education and career planning.
8. An all out effort to hold the line on the cost of health insurance.
9. To aid in the promotion and development of job opportunities for persons afflicted with rheumatoid arthritis or any other type of disease which prevents a person from entering regular employment channels.

The insurance industry does not offer a panacea. It cannot meet the future challenges alone or perpetuate its existence unassisted. It must expand its present affiliations and intensify its negotiations with:

1. The medical associations
2. The hospital associations
3. The great organizations such as The Health Insurance Association of America, The Health Insurance Council, etc.
4. The splendid organizations such as The Arthritis Foundation
5. It must give greater support to community health planning with:
   - A. Active involvement in community health planning groups through appropriate participation of qualified insurance personnel in state and areawide groups.
   - B. Financial support of community health planning operations by allocation to appropriate groups of funds provided on an industry-wide basis.
   - C. Technical backup of industry participants in community health planning assignments with background material, information and counsel.

Finally, the government is becoming increasingly involved in meeting the costs of health care. However, there are gaps in the government programs which render it necessary for private insurance to fill such gaps. Furthermore, it is clearly established that social type health insurance is far from being completely adequate, that there is now and will continue to be a need for private insurance and that, in fact, there will be an increase in private insurance underwritings. This seems to be borne out by the general opinion that health insurance provided through statutory means cannot be assumed to match pace with an escalating economy as readily as benefits provided through private sources.

The insurance industry recognizes fully that the stage has been reached where the public believes that adequate health care should be made available to all. Obviously, this adds even greater impulses to the challenges and renders inescapably urgent the necessity for a great cooperative effort between the insurance industry, the government at every level, the voluntary health interests, community services, etc. Significant steps in the direction of cooperative enterprise are being taken at this very hour. I refer to the National Conference on Private Health Insurance now taking place in Washington, D. C., and called by

the Department of Health, Education, and Welfare.

Participating in the conference will be representatives of insurance companies, Blue Cross, Blue Shield, Prepaid Group Practice Plans, American Medical Association, National Medical Association, American Hospital Association, employers, organized labor, state insurance commissioners, and the Federal Government.

The insurance industry, through its vast contributions to the health care of mankind, through its great resources, financial stability and integrity and through its countless thousands of independent agents and representatives who reach into every home in this country, has given a demonstration of individual and collective initiative and free enterprise that should be preserved. If the great cooperative effort accomplishes those things that I have outlined in addition to the many things that are beyond my comprehension or ability to express, then I consider that there should be no concern about the economic potential and health care of our citizenry.

Mr. Charles Plumer is vice president —group administrator, The Union Labor Life Insurance Company, New York.

How Do Rheumatic Diseases Relate To Economic Potential As Influenced By:

Management

MR. RAY A. HULCE
Dearborn, Michigan

Let me begin by identifying myself. I come from the automobile industry, and work for the Ford Motor Company. My interests in work are in the area of making scientific developments into new businesses.

The title electrocure operation has nothing to do with medicine and it is no magic black box.

My role is to convey some views of management, the industrial employer toward the arthritic. The views I bring, while having a foundation in the experiences and practices of the Ford Motor Company, are, I believe, reasonably representative of large industry that has a concern for its corporate citizenship responsibilities.

In industry concern for the arthritic is not isolated or segmented from concern for other types of affliction which in some way cause an employee or a potential employee to be less than 100 per cent effective. I feel this is an important distinction to convey to you doctors, and to understand, that, while the medical profession is cause-and-treatment oriented, in industry as it relates to arthritis, we're primarily effect oriented.

And we address ourselves to the problem of the handicap without respect to segmenting the cause. In addition to the human motive recognized as a positive benefit, we also recognize some profit-related motives and values in carrying on efforts to keep employees at maximum effectiveness.

As the technology in industry increases, there are progressively fewer unskilled workers in the job mix and progressively more semi-skilled and highly skilled jobs in which a company has a great amount of worker investment.

Consequently, when a worker cannot function and he possesses a high skill, the business itself suffers to the extent of his inefficiency.

It has been said that arthritis is at its severity during the ages 45 to 64, which happens to coincide with the ages at which a worker is at his peak of effectiveness and therefore, we have an added stimulus to address ourselves to the problem.

Out of this has evolved at Ford, a five-point program related to the concern for the arthritic and other handicapped persons in industry. I couldn't help feeling very grateful when Dr. Brewerton and Mr. Daniel explained their program, because it struck me as the ideal agency that we would like to see in our endeavors.

Our program, essentially, boils down to these five points. The first is job placement, in the category of new employees and I might add that the job placement function is handled by full-time people on the company roll, who are concerned with the very same items that Mr. Daniel is concerned with: job understanding, work environment understanding, communication with the medical profession on the nature of the man's handicap, and finally, acting somewhat as a catalyst or a missionary, I don't know what word you would use, to bring the handicapped person and the work environment situation together in a successful manner.

There's always a touchy question with respect to newly hireds who are handicapped vs. people who have become handicapped after they have been hired, and it relates to such things as union rules, that a handicapped person cannot be hired if there are any handicapped persons on lay-off.

It has to do with the fact that on occasion, a disease which is quiet, might be re-introduced due to the work environment, and therefore, liabilities assume that are necessarily the employer's initially.

With respect to seniority employees, our view is a very strong one, that if the man is capable of performing work, there must be a job somewhere for him, and great efforts are extended to locate them and see that it works out properly.

A second area of concern is treatment and rehabilitation and in this area, our efforts are concerned with assuring as we can, that an afflicted person is receiving a well-documented type of treatment, and in some instances this involves recommending that the person bring in a consultant or that he go to a clinic or something of this sort to get the best possible treatment that can be achieved.

Also, where we think it will help, we assume the initiative in contacting the person's physician to explain to him, our view of the problem, and how it is manifesting itself in the work place, in an effort to stimulate a better understanding of the treatment that should be followed.

Third, we carry on a program of

employee-education, in which we encourage employees who feel they have some type of a problem to seek treatment early, so that the problem can be related at an early date, and regular treatment begun. In this regard we try to have an understanding attitude on the part of the local supervision with respect to people being away from their jobs for treatment, in the belief that half a day off for treatment is better than two weeks off because of delay of treatment.

However, this is a matter of dealing with human beings, and it's a matter of getting the word down to all levels to have it work successfully.

The next area that we concern ourselves with, is what we call medical leave control. This has to do with being sure the right people are on leave, that they are not on the job if they're not fit to work and also being sure that when a person is ready to come back, that he does come back, not too soon and not too late. I might say that with the wealth of miracle benefits and idleness benefits and the insurance plans that take care of a man when he is not earning his pay, we're finding there's a greater inclination to stay away from the job when you are able to work than there has been in the past, and we've assumed some initiative through the personal physician in discussing this type of an issue if we think it exists.

Lastly, in our five-point program, we are concerned with the environment of the workers, and we have men who are assigned full-time to be moving through the work areas, looking for conditions that might induce a problem, looking for conditions that might aggravate a problem, and also, particularly looking for the type of condition where an employee who in some way has been handicapped, might aggravate that handicap because of the work place.

In total, we have in one main plant of the company, the Rouge Plant, which employs about 36,000 hourly workers; we have approximately thirty people, non-professionals who are working full-time in connection with assisting the handicapped work environment.

There's one message I want to bring to you people, that I hope you'll take away if nothing else, and that is, there is need for a constant dialogue between the physician and the employer in every community, in every city and state in this country. The lack of understanding is one, in my view, that is very hard to sensibly explain when we're dealing with intelligent people on all sides.

We have found that the union, if the union involved has a man, where the local physician will give his efforts and time to learn, where the employer will give his efforts and time to learn, that generally you have a very satisfactory civically responsible area with respect to handicaps, and generally, where the problems show up, it's because dialogue hasn't been carried on properly.

Mr. Ray A. Hulce, president of The Arthritis Foundation, Michigan Chapter, Detroit, Michigan, is the Electrocure Operations Manager, Industrial and Chemical Products Division, Ford Motor Company, Dearborn, Michigan.

Prognosis For Employability In The Major Arthritides Rheumatoid Arthritis, Osteoarthritis and Gout

OTTO STEINBROCKER, M.D. *
New York, New York

The Program Of Unemployment Due To Arthritis

Each type of arthritis under consideration may present acute episodes, especially gouty arthritis, but generally rheumatoid and degenerative joint involvement produce chronic joint disease. By its persistence the arthritis sooner or later raises the question of the *prognosis for employability*. Actually, in a study of chronic conditions causing limitation of activities, an extensive Health Interview Survey of the U. S. Department of Health, Education and Welfare found that activity limitation by arthritis alone annually occurred in 26 per cent of the subjects with arthritis (Figure 1). Another 23.9 per cent with an additional medical condition also reported arthritis as an associated contributing factor in the disability.[1] Eighty-five per cent of the arthritics, it was estimated by the Survey, were forty-five years of age or more.

The Public Health Service further determined from its Survey that 10 per cent of these arthritics were completely disabled. Each year, therefore, because of arthritis, nearly 700,000 people are unable to follow "their major activities—working, keeping house, attending school, etc." [1] (However, the arthritic disabilities were not separated into the specific articular diagnoses.) The average number of days of restricted activity and confinement to bed was greater for women at most age levels. Prevalence rates also were higher among females. At the peak ages of 45-64 years, males showed a slightly higher number of restricted activity days, 14.8 as compared to 12.3; overall, males averaged 14.4 days of restricted activity to 14.8 for females as an annual average. Males had a yearly average of 4.1 complete disability days (in bed) to 4.7 for females (Table 1).

The author wishes to express his thanks to Miss H. M. Vavra and S. B. Brinkley, M.D., of the U. S. Public Health Service for their information and assistance.

Problems of Arthritics In Getting Employment

In considering employability, it is necessary to make a distinction between the working person who, already employed for a greater or lesser length of time, develops the usual limited attack of arthritis. Such employees, it has been found, lose an average of 4.1 complete disability days a year for males and 4.7 for females.[1] They generally return to the same jobs which await them. On the other hand, unless possessing an unusual skill or having some much needed technologic training, when anyone suffering from arthritis must stop work for a great length of time, this individual usually must find new employment. Also, when an arthritic looks for work for the first time, it is a similar, difficult problem.

This difficulty is reflected in a report of the New York State Employment Service which found that only one of four job applicants with arthritis was placed in a job.[2] The ex-

perience of this agency also showed that two out of three who applied to it had sufficient work (twenty weeks) during the previous year to be eligible for unemployment insurance benefits; three out of five had been unemployed less than three months; three out of four were forty-five years of age or more, adding an age factor to complicate the placement problem. Nevertheless, with experts in selective occupational placement, this agency has found jobs for 80 per cent of the forty-five plus age group of arthritic applicants.

Factors Influencing The Outlook And Development Of Arthritis

The factors influencing the development and outlook for any particular type of arthritis naturally play a similar role in the *prognosis for employability* of the worker with arthritis. Sex, race, age, type of work, heritable tendencies, environmental or climatic conditions, the emotional or physical state, and others, have a demonstrable bearing in different forms of arthritis. Other more direct and controllable influences will receive attention here.

The Factors Influencing The Prognosis For Employability

The factors in the progress of joint disease which are controllable, to a great degree, *influence the prognosis for employability*. They are:

1. Early recognition and care of the disease.
2. The past history and clinical pattern, of a mild or severe, steadily active course; or of an episodic course with remissions (more favorable).
3. The pace of progression of the joint involvement, and the degree of limited function already present.
4. The extent of joint damage, and the location affected, such as the hips and other weight-bearing joints.
5. Responsiveness to previous medical management.
6. Rehabilitation, vocational training and placement, depending on:
   A. Motivation of the patient.
   B. Cooperation of the employer.
7. The psychic stability of the patient.
8. Socio-economic aspects of the patient's situation.

Some of these factors have been found important in long-term clinical observations by Ragan,[3] as well as in the studies of the U. S. Public Health Service,[1] and I am sure by most interested observers. All of them are notably decisive in rheumatoid arthritis, but they also apply to osteoarthritis and, at times, to gout. As the decades advance (45-55-65 years, and higher), the prevalence of arthritis, with partial or complete disability, increases, especially in rheumatoid and degenerative joint diseases, and to a much lesser extent, in gout.

Rheumatoid Arthritis

It is widely accepted that approximately 10 per cent of patients with rheumatoid arthritis develop a persistently severe or unrelenting, steady activity that leads to a prematurely disabling condition. Nevertheless, Lowman has found that "80 per cent of rheumatoids continue to function in their usual duties despite symptoms." The conscientious, periodic, long-term study by Ragan and Farrington[3] of an initial series of 500 rheumatoid patients gives revealing information. These were clinic patients, presumably in the lower income groups (Table 2). Sustained disease previously present for a good length of time and the presence of rheumatoid factor in the serum, especially in patients under thirty, were considered poor prognostic signs. It is notable that the number of patients in the early and in the late stages showed a great reversal from the first to the last reevaluation. Still, the fifty plus per cent fully employed at each periodic examination remained within remarkably close limits, regardless of the increasing number in the more advanced stages (Table 2). The proportion of those in part-time employment also continued at a respectably consistent level in spite of the growing proportion of advanced rheumatoid disease.

In an industrial study of 331 employees by Lincoln and Cobb over a span of twenty-eight months, 5 per cent of these workers at some time during this period fulfilled the A.R.A. criteria for definite rheumatoid arthritis.[5] Nevertheless, their time lost was only a little greater than that of other members of the staff, most of whom were in "blue collar" jobs. The authors concluded,—"In contrast to the disease in patients seen in clinics and consulting rooms, in these patients it seems to run a benign, remittent course with mild to moderate symptoms and little disability." Evidently, different socio-economic groups were represented in these separate studies with their varying conclusions.

It is widely agreed that early recognition and medical care are important in the prognosis. The observations of the Public Health Survey[1] that increased arthritis and disabilities occurred in the lowest economic groups getting little or no care tends to support this view, although additional factors may be involved. The past history and course of the joint disease, if they have been severe, have similar implications for the prognosis and future functional capacity. This is particularly true if the damage to articulations, especially weight-bearing joints, already is of any great degree, or if any joint contractures are threatening. The application of medical management as early as possible is important in influencing the factors mentioned, as well as in the further prognosis. We have no cures, but much can be done for comfort and articular function.[10]

In special cases rehabilitation, vocational training and selective placement can make a valuable contribution.[2] In a New York State "back-to-work" program conducted by Manheimer and coworkers, individuals with arthritis received counseling, vocational evaluation, training and brush-up courses to prepare them for placement in new jobs or occupations. Two-thirds of the group had rheumatoid arthritis; the remainder were equally divided between osteoarthritis and other forms of rheumatic disease. In an eight-year period, 41 per cent of the 533 arthritics in the program were placed in competitive jobs.[4] "A follow-up study of ninety-nine cases found in 90 per cent were still on the job, eleven having worked for more than two years."[4] In 1966, the State-Federal rehabilitation program "rehabilitated 2,534 persons disabled by arthritis and rheumatism."[6]

The patient's psychic stability and adjustment to the illness and its requirements are important in the prognosis for employability. A good rapport and understanding encouragement are helpful. Psychotherapy may be needed to supplement medical measures.

Motivation is one of the most important, intangible assets in the results obtained in employability, continuation at work or reemployment. It seems to help to counteract otherwise greatly limiting joint involvement

and somehow to foster functional capacity, an urge to get along with the little mobility left. (Figs. 2, 3, 4).

The cooperation of employers and the *availability of more job opportunities* for arthritics in the competitive labor market are necessary in the practical resources for the employability of the worker with rheumatoid arthritis and other arthropathies.

Socio-economic aspects of the patient's situation are more important than is realized by those of us who work in large cities where clinics long have been available to the lower income groups. The Public Health Service study presented in the Source Book of Arthritis has revealed that *20* per cent of those interviewed whose income was under $2,000 (per year) *never* saw a doctor about their joint trouble. This group included many older people.[1] The record gradually improved in the higher categories to the $7,000 plus income group, of whom 12.6 per cent never had medical care for their arthritis. Altogether, *two million interviewees with arthritis reported never having seen a doctor*, one-third of them in the $2,000 or less income group. Their annual disability increased as income decreased from 10.1 days of restricted activity and 2.4 days of bed disability in the $7,000 plus group to 27.4 days of restricted activity and 7.5 days of bed disability in the $2,000 a year group. These are significant data on areas to be improved by future educational and other activities by some suitable agency.

Osteoarthritis

Degenerative joint disease is the most prevalent form of arthritis. Naturally, its frequency and extent increase with age. A surprising amount of degenerative or proliferative alteration may occur without producing symptoms. Yet, a small degree of degenerative change at a knee, hip or spine may be associated with synovitis or radicular pain and disability. Medical management and orthopedic aids, even surgery, may control symptoms and prolong good function. The continuation of work in spite of impressive pathology is commonplace. Kellgren and Lawrence, in a long-range population study, found that degenerative joint disease in the 56-64 age group increased to 83 per cent of males and 87 per cent of females with degenerative changes of the spine and discs.[7] Females usually showed, in addition, multiple joint involvement, especially at the interphalangeal joints of the fingers; males showed changes affecting chiefly the spine and hips. It is interesting, particularly in Pennsylvania (at least in the mining areas), that the British observers concluded that trauma and occupational strain, like that of laborers and miners, determine the site and severity of osteoarthritis and disc degeneration. Of couse, the frequency of degenerative joint disease according to occupations will vary with the area and type of heavy industry predominating. In the U. S. the Public Health Survey indicates that farmers show the highest prevalence of degenerative joint disease.[1]

Some idea of the loss of working time in industry on account of degenerative joint disease is given in the Consolidated Edison study of absenteeism due to rehumatic conditions (Table 3). There was an annual average loss of four days compared to ten for rheumatoid arthritis and seven for gout. These represent acute or subacute episodes. Specific situations may develop which become troublesome or acute, such as at the spine, hip or knee, and sometimes prolonged. In degenerative joint disease repetitive or chronic disabling symptoms are frequent and then produce unemployability.

Some index to the relationship of degenerative joint disease to employability is seen in "the 30,000 annual applications for disability benefits each year under the Social Security Administration's Old-Age, Survivors, and Disability Insurance."[11] Fifty-six per cent of the applicants had osteoarthritis; 72 per cent, rheumatoid arthritis. Eighty-two per cent were 50 years of age or older; 80 per cent were men. Among rheumatoids, 60 per cent were allowed the benefits; among those with osteoarthritis only 30 per cent were allowed. Many workers or homemakers with disabling arthritis do not qualify for this coverage.

Gout

This disease gives acute episodes which generally subside quickly. With present day medications tophaceous gout, urate deposits and involvement of viscera are not as likely to occur or to give the chronic disability of classic gout.

Hall and coworkers, in a study of the epidemiology of gout followed biennially, found that attacks of gout occurred in 1.8 per cent of those with serum uric acid of 6-6.9% mg.; in 11.8 per cent of those with the uric acid level at 7-7.9 mg.%; and in 36 per cent of those with levels above 8 mg%.[8] Of those developing attachs of gouty arthritis, one-fourth got only one attack in the twelve years of the study, but the average number of attacks for the gouty subjects was five. Urinary calculi appeared at least once in 11 per cent. The articular episodes were the usual attacks. Eighty-four per cent had at least one bout of podagra. No mention of the loss of employability is made.[8]

Unemployability due to chronic gouty arthritis is rare in practice. It shows up in group statistics in only a fraction of the complete disability resulting from the other arthritides. "A measure of the impact of arthritic disorders on the working population may be found in 'Social Security Disability Applicant Statistics for 1964.' During that year a total of 6,104 persons with diseases of the bones and organs of movement were determined to be disabled by the criteria established by the Social Security Administration in the disability insurance program. Of these, 216 persons with gout were determined to be disabled, but 2,036 had osteoarthritis and 2,286 had rheumatoid arthritis."[6]

Summary

Exact information on each of the chief arthritides presently is not adequate to reliably estimate the prognosis for employability. Absenteeism and the effect of joint disease on disability have been reported. Prospective, periodic long-range observations yielding such data in a representative cross-sampling of the self-employed, executive, working and home-making population are not available. These would provide well-rounded and helpful contributions.

From the recent enlightening studies of various departments of the Public Health Service and from those of a number of individual investigators, as well as the projects of the special agencies already mentioned, at this time the following conclusions may be stated:

1. In 10 per cent of individuals with rheumatoid arthritis, the disease early becomes disabling. From clinical observation it has been determined that another 10 per cent develop cumulative and final disability at some time in the patient's working life. The *prog-*

nosis for employability appears to be good in 50-80 per cent of rheumatoid patients according to the socio-economic status and medical care, even with advancing rheumatoid involvement. [3, 9]

2. For osteoarthritis there are no overall figures, but apparently it becomes increasingly disabling in 10-15 per cent of patients from the sixth decade on, in the data already cited. The *prognosis for employability* is somewhat better, according to present information, than for rheumatoid arthritis.
3. I have found no adequate information for permanent disability or unemployability in gout, except the disability among Social Security applicants.[6] Absenteeism due to acute attacks evidently is not frequent, judging by the industrial data presented, but even that should be reduced in time with the more effective drugs that have become available. The *prognosis for employability* is best in gout.

The more or less favorable *prognosis for employability* in all categories depends on the early recognition and suitable care of the joint disease, a stimulating level of motivation in the patients and the creation of more employment opportunities for those with articular disabilities.

Obviously, in view of the many factors influencing joint disease and thereby determining the prognosis for employability, evaluations must be individualized. More detailed future information on disability probably will permit more exact general prognostications for each type of arthritis, and possibly for each stage of the particular joint disease, when first seen.

It is clear from the information obtained from the Survey of the Public Health Service [1] that a great need exists for an educational program, especially among individuals in the lower income groups. The benefits of medical care and proper treatment of joint disease for improved health and a better *prognosis for employability* make a message that deserves to be delivered.

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The Physicians' Headaches: Syndromes Of The Back, Neck, and Shoulder

The Industrial Physician

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Our industry is engaged in the manufacture of all of the components of a modern telephone system. We manufacture the cables, the telephones, the switchboards and PBX devices and even micro-wave equipment, a "cousin" to radar. My responsibility in North Jersey embraces the health care for about 15,000 employees under one general location, including approximately 8,000 female employees.

Before we begin the presentation of the case histories, you might find of interest a few words of general background in this problem. I have combed the records to get a feel for the magnitude of the problem as industry sees it today. Although the male of the species is the traditional breadwinner and is exposed to a heavier type of work and has more arthritis, it was easier to identify the incidence of arthritic disease among the female employees. I know that you have spent several hours in discussing this problem, but let me put into focus so we can then discuss the cases I have to present. Our company last year (1966) removed 47 of 15,000 employees for reasons for disability; nine had arthritis, seven men, two women! I have listed by service bands the number of cases of arthritis which have come to our attention during the year 1966 (Table I), according to the International Disease Classification Code. Code 720 is "Acute Arthritis due to Pyogenic Organisms"; 722 Rheumatoid Arthritis; 723 Osteoarthritis, and so forth. In the left hand column under each category you will find the number of cases that were disabled during the year, and the right hand column next to them, the days of disability that were associated with these cases. Now recall these are female employees only, in the general ratio of four hourly employees to each salaried female. You will note in the summary, at the bottom, there were 317 cases, totaling 7,488 days for an average of 23.6 days per case. Under the category of 720, there were 20 cases totaling 400 days of sickness absence; Category 722, "Rheumatoid Arthritis," 43 cases with 1,454 days of absence; Code 723, "Osteoarthritis," 54 cases with 1,512 days of absence; Code 724, "Other Specified Forms," 9 cases with 151 days; Code 725, "Arthritis or Polyarthritis Unspecified," 74 cases with 1,707 days, and finally Code 726, "Muscular Rheumatism of Low Back, Shoulder and Neck," showing 117 cases totaling 2,264 days of absence.

TABLE I

Disability Days Due to Rheumatic Diseases
international disease classification

Code 720—Acute Arthritis due to Pyogenic Organism
722—Rheumatoid Arthritis and Allied Conditions
723—Ostcoarthritis and Allied Conditions
724—Other Specified Forms of Arthritis
725—Arthritis (polyarthritis), unspecified (connotes vagueness)
726—Muscular Rheumatism—(of low back, shoulder, and neck)

Service (Yrs.)		*720*		*722*		*723*		*724*		*725*		*726*	
		C	*D*	*C*	*D*	*C*	*D*	*C*	*D*	*C*	*D*	*C*	*D*
0 to 2	H	3	65	2	30	1	20	—	—	6	84	11	155
	S	—	—	—	—	—	—	—	—	—	—	2	27
2 to 5	H	1	7	4	146	5	101	1	9	11	223	22	315
	S	—	—	—	—	—	—	—	—	—	—	—	—
5 to 10	H	1	6	9	368	5	80	3	33	14	279	40	797
	S	—	—	—	—	1	11	—	—	—	—	—	—
10 to 15	H	7	147	13	478	13	449	2	33	11	207	20	458
	S	—	—	—	—	—	—	1	22	—	—	—	—
15 to 20	H	5	125	6	237	14	357	1	13	10	263	10	161
	S	—	—	4	57	—	—	—	—	1	10	—	—
20 to 25	H	1	10	3	59	4	124	1	41	16	527	10	335
	S	2	40	—	—	—	—	—	—	—	—	—	—
25+	H	—	—	2	79	9	336	—	—	3	73	1	9
	S	—	—	—	—	2	34	—	—	2	41	1	7
TOTAL	H	18	360	39	1397	51	1467	8	129	71	1656	114	2230
	S	2	40	4	57	3	45	1	22	3	51	3	34
	Comb.	20	400	43	1454	54	1512	9	151	74	1707	117	2264

H = hourly S = salaried
C = number of cases D = days of disability

I present these figures to you with a number of reservations. First, we have to take the diagnosis given to us by the family physician in many of these cases, and he is sometimes not quite sure whether it is an arthritis or whether the employee has a muscular strain or something of a similar nature; the easiest way for him to send a physician's certificate is to simply label it an arthritis or a muscular rheumatism. One can easily understand that some of these figures could be open to challenge based on the sophistication of the observer. One other thing that I would like to call to your attention is the column on the left showing the years of service. One would certainly expect to find a heavy predominence, for example, of osteoarthritis in the employee with twenty to twenty-five years of service. This is a woman in her middle years or late middle years and, strangely enough, we only have four cases with 124 days listed here.

You get the feeling that some of the traditional views on arthritis are open to question and perhaps need a fresh look and some new ideas. An entirely new approach could arise from a workshop such as this one.

Finally, in our industry, we have an interest in providing an employee with work he can do when he first returns from illness. In many cases we can provide work which does not require strenuous use of a limb for a short period of time, so they can be rehabilitated on the job. I think it's probably the biggest single factor that accounts for the relatively short number of days per case, 23.6. One could easily see that a person with arthritis might be disabled for a longer period of time unless special sheltered work were provided for him on return. This we try to do, with the idea that once they are under the roof and working and coming in each day, they do tend to recover from their illnesses more quickly. If they feel they are needed and feel they are productive, their rehabilitations have already begun.

The following four case reports illustrate some of the problems. The first is a case of osteoarthritis impinging on the employee's ability to continue at work.

Case #1—Miss A. K. (E-76098) is fifty-four years of age and has had twenty-six years of service with this Company. She is an unmarried female, living by herself with no income other than her wages.

At the time of her original employment, she was hired as a restaurant food handler. Her physical examination at this time did not show any significant findings other than the fact that she was only 5′ 2″ tall, and weighed 161 lbs.

Throughout the subsequent years, she had one episode of "allergic dermatitis" in 1949, "neuritis" in her left thigh in 1955, several episodes of upper respiratory infection of a minor nature, and one prolonged episode of poison ivy in 1962 which involved her hands, arms, legs, and abdomen. None of these disabilities were prolonged, and her longest period of absence, during her term of employment, was the 14-day absence in 1955 with her "neuritis." At age 45 she had already completed her menopause and was felt to be in good health. She had now been transferred to the shops where she was employed as a bench hand performing assembly work on small parts. She has voluntarily dieted, and now weighs 102 lbs.

In February of 1967, she was seen in the Medical Department complaining of pain in her fingers with particular reference to her left thumb, which was swollen at the distal inter-phalangeal joint. X-ray of hands on 3/1 and 3/7/67 were as follows:

3/1: *Left Thumb:* Advanced osteoarthritis with loss of interphalangeal joint space and hypertrophic lipping on both sides of joint. One osteophyte lies free in soft tistues on lateral aspect of joint but does not appear to be a recent fracture. Edges are smooth. No bone tumor.

3/7: *Both Hands:* Advanced osteoarthritis bilaterally with no significant change since March 1, 1967.

She also volunteered the information that she has begun to have transient aching pains in her back, particularly in her neck, and also has difficulty in remaining in a seated position for any long period of time. As a courtesy to her and her family physician, we x-rayed her cervical, dorsal, and lumbar spine. Report of the radiologist is as follows:

7/3/67: *Cervical Spine:* Advanced osteoarthritis and disc degenerative disease of C-4 through C-7 with

narrowing of foramina by osteophytes.

Dorsal Spine: Osteoarthritis of a degree not unusual at age fifty-four.

Lumbosacral Spine: Schmorl's nodes as indicated. L-2, L-3, interspace and L-3, L-4 interspace narrowing indicates disc degenerative disease. List of lumbar spine to left at L-4, L-5 interspace. Moderate hyperthropic lipping on margins of lumbar vertebrae.

This is a female employee who at age fifty-four is beginning to show early signs of osteoarthritis. She has had to have a change in her work assignment to accommodate her disability in her hands. It is conceivable that if her arthritis continues at its present rate, she may have other disabling symptoms which may prevent her from performing any type of factory work because she would be unable to maintain satisfactory attendance. Depending on the degree of sophistication of her medical care, by way of her private physician, it is possible that she could have many more working years. However, I can foresee that she will need extensive care and rehabilitation in the coming years. Her laboratory findings are in Table II.

TABLE II

Case I—Laboratory Findings

Glucose	110 mgm % (Normal—70 to 110 mgm %)		
Urea nitrogen	18.9 mgm %		
Uric acid	3.5 mgm %		
Cholesterol	175 mgm %		
Bilirubin total	.9 mgm %		
Calcium	10.2 mgm %		
S.G.O. transaminase	16.0 units		
Alkaline phosphatase	6.3 K A Units		
Protein total	7.1 %		
Albumin	4.8 %		
Urinalysis	3-14-67	3-16-67	8-03-67
Reaction	Acid	Acid	Acid
Spec. Grav.	1.023	1.022	1.023
Protein	2+	Heavy trace	1+
Glucose	Neg.	Neg.	Neg.
Micros.	Many cocci Many uric acid	Mod. cocci Otherwise neg.	Mod. cocci Otherwise neg.
Sed. Rate	15 mm/hr		17 mm/hr
Hemoglobin	13.4 gm		13.5 gm
Hematocrit	41%		41.5%
Leucocytes	5,100/cu mm		6,150/cu mm
Poly.	60%		58%
Eosin.	4%		4%
Lymph.	32%		33%
Mono.	4%		4%
Baso.	0		1%

Case #2—Mr. J. B. (E-78735) is fifty-five years of age and has had twenty-six years of service with this company.

At the time of his original employment, February 27, 1941, his physical examination did not reveal any significant or abnormal findings. Review of his sickness record shows an absence with toothache in 1942, appendicitis in 1943, tonsillectomy in 1944, right inguinal herniorrhaphy in 1945, and an incisional hernia repair at appendix scar in 1949. Beginning in January 1951, he had a series of absences which were diagnosed as "virus infections." These were manifested by chills, fever, general migratory aching joints, occasional diarrhea, and sore throat. On one occasion, he had a reaction and rash from penicillin.

Diagnosis of rheumatoid arthritis was finally established in 1953 when the pattern became clear and he had significant symptoms of joint pain and swelling of the shoulders, elbow, and knee, then the shoulders, hands, and knees again. He had a series of gold injections and forced himself to remain active. When the process finally "burned out," he was left with the following x-ray findings:

8-10-67: *Right Knee:* Severe osteoarthritis with degeneration of both cartilages producing marked joint narrowing. Femoral and popliteal arteries are calcified.

Right and Left Hand: Hands show severe rheumatoid arthritis with destruction of articular margins, subluxation and deformities.

Dorsal Spine: Moderate osteoarthritis.

Lumbosacral Spine: Relatively normal. Lumbar aorta is calcified.

In spite of these remarkable illnesses and his present deformities, he has had relatively few absences since the onset of his problem, and he has been able (with difficulty) to perform his duties as a machine setter with a twenty-five pound lifting restriction. His tremendous motivation has, thus far, sustained him to perform exercises which have kept most of his joints useful. He is apprehensive concerning the use of cortisone or any steroid compound and is unable to tolerate salicylates. He has never had any phenylbutazone compounds.

Our chief concern with regard to this employee is his future ability to continue at work. He already has a sheltered work assignment which requires a lifting restriction together with a walking and standing limitation. It is doubtful that with his hands as crippled as they are that he can continue to perform any movements where adjustments at his work require fine sensitivity. To further complicate matters, during the past two years he has had two operations on his left inguinal area, one for a femoral hernia and the second for an inguinal hernia, both of which were alleged to be caused by his work. At the present moment one can easily foresee that he will have major problems within the near future.

His laboratory findings are in Table III.

His blood count and urinalysis are within normal limits. Our normal values for uric acid in males are 2 to 6.5 mgm %. This test has not been repeated.

The problem of shoulder pain or derangement which concerns an employee in the manufacturing industry is one which is of significant impor-

TABLE III
Case II—Laboratory Findings

Sed. Rate	13 mm/hr
Glucose	97 mgm %
Urea nitrogen	11.4 mgm %
Uric acid	7.8 mgm % (normal 2-6.5 mgm %)
Cholesterol	200 mgm %
Bilirubin total	.6 mgm %
Calcium	9.7 mgm %
S.G.O. transaminase	18.0 units
Alkaline phosphatase	11.0 K A Units (Normal 2-12 KAU
Protein total	8.0%
Albumin	5.3%

tance. Two cases are presented below to demonstrate how a physical disability in this area will impinge on their abilities to perform thus affecting their livelihoods.

The first case: Mrs. E. V. (E-211846) is fifty-four years of age and has been employed in an assembling operation for twelve years. Her work requires that she assemble small piece parts on a small fixture and then reach forward to pull down an automatic screwdriver to fix them together. The screwdriver is at high level and is located about eighteen inches in front of her face. The piece parts are delivered to her in small trays and require that she reach both to the right and to the left, a distance of twenty-four inches maximum from the mid line. About ten times per hour she raises her arm above shoulder level to place the assembled item into an outgoing bin.

Past medical history on this employee is not remarkable. Her preplacement examination did not reveal any abnormalities. She has had very little absence during her twelve years with the exception of an episode of metrorrhagia ten years ago, and several minor "virus" attacks. In March, 1967, she began an absence because of pain lateral to her right shoulder. Because of the pain, she was sent to see her private physician whose diagnosis is "acute and subacute subdeltoid bursitis." She was treated with repeated injections into the bursa and has been returned after a twelve-day absence to performing restricted work which does not permit her to raise her arm above shoulder level.

The x-ray report shows "extensive peritendonitis calcarea."

The second case: Mr. W. W. (E-101969) involves a male electrician who is fifty-four years of age and has twenty-five years of Company service. His preplacement examination was not remarkable, and through the years his only sicknesses were due to sore throat (three times), grippe, virus, and one episode of gastrointestinal malfunction. He first came to our attention in 1960 at which time he had his initial episode of bursitis in his *right* shoulder. This was treated by his family physician as a non-Company condition. Six years later, April, 1966, he presented a Company-connected condition in his *left* shoulder. Since his work involves a lot of climbing and pulling himself into position, and working with his arms raised, we could not controvert his allegation that the condition arose out of and in the course of his occupation.

X-ray reports on two occasions are as follows:

8-29-60: *Right Shoulder:* There is a calcific deposit at the head of the humerus. Later film in 1965 showed multiple calcific deposits in the rotator cuff of the right shoulder.

4-15-66: *Left Shoulder:* Peritendonitis calcarea (bursitis).

Also calcification in acromiol clavicular ligament. He has been on restricted work which requires limited use of his right hand and arm, and a limited lifting restriction of twenty-five pounds weight or effort. Treatment following these episodes have consisted successively of injections, Butazolidin,* and finally deep x-ray radiation up to 600r/a.

This is a common problem in industry and a delicate one with regard to Workmen's Compensation. It is our opinion that in the latter case the calcification and basic condition antedated the episodes. However, industry is frequently obliged to accept the responsibility for the condition, based on the principle of possible aggravation due to the work assignment.

* *Geigy Pharmaceuticals.*

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DISCOVER AMERICA IT'S SOME BACKYARD

The Physicians' Headaches: Syndromes Of The Back, Neck, and Shoulder

The Rheumatologist

GEORGE E. EHRLICH, M.D.
Philadelphia

The problem of the neck, shoulder, and back encountered in industry are not essentially different from those met with generally in practice. The disorders fall into two general categories. The first of these encompasses those rheumatic diseases that nevertheless permit the patients to continue working. The disease may influence the work because it produces pain and limitation of motion, or may necessitate adaptation of the working conditions. Secondly, rheumatic symptoms may themselves be a result of the type, or conditions of work.

In the first category, we find both organic and psychogenic syndromes. In a Conference on Rheumatic Disorders in Industry,[1] Bunim deducted the relative prevalence in workers as degenerative joint disease, 37 per cent; bursitis, 13 per cent; gout, 11 per cent; rheumatoid arthritis, 8 per cent; and others, including all the psychogenic syndromes, 31 per cent. Most studies of the prevalence of these diseases in the general population arrive at much higher figures for rheumatoid arthritis. The explanation may be that the rheumatoid patient, at least of that day,—the conference was in the early 1950's—could not easily find employment or do work, and the disease is more prevalent in women who, at least at that time, accounted for a minority of industrial workers. One would hope that the percentage of employed rheumatoid arthritics has risen since 1953. Prophylactic and restorative surgery and better diagnosis ought to have helped in that direction. Indeed, Cobb's studies suggest that many rheumatoid patients may have such mild manifestations, that they often remained undiagnosed.[2]

Pain in the neck because of psychogenic factors or after long hours of holding the head in a fixed position can plague almost anyone. Painful shoulders, collectively referred to as bursitis by doctors and patients, follow unwonted exertion, or are part of the aging process. The human back was obviously not constructed for an erect posture, so the causes of backache are myriad. Nevertheless, in quantity, quality, and sequels, these areas present a major problem in morbidity to industry.

Psychogenic rheumatism is very common. The foreman may be seen as "a pain in the neck." "Oh, my aching back" may greet an unwelcome new assignment. At best, such psychogenic rheumatisms result in decreased efficiency. However, abnormal posture sustained for a prolonged period of time can lead to actual crippling, with wasting of muscle groups, and bizarre postures. Patients so crippled not only suffer and may be unable to work, they may also be eligible for disability payments. It is impossible to obtain an accurate estimate of the magnitude of the problem. It is fair to assume that in terms of man-hours lost, income not earned, taxes not collected, medical costs, and disability payments, the total expense is enormous. I think the official estimate may be considerably lower than the actual cost.

But psychogenic rheumatism need not be pure, in the sense that there is no underlying organic disease. Superimposed and residual psychogenic rheumatism also present major problems.

The patient whose neck is stiffened by painful muscle spasm radiating into his arm may well present roentgenographic evidence of spurring, or narrowing of the apophyseal joints. We diagnose cervical spondylosis, sometimes cervical osteoarthritis, but our treatments work, or fail to work, seemingly without regard to the underlying lesion. Brewerton [4] obtained considerable relief for his patients by treatment with salicylates, and various physical measures, including sham diathermy (in which the machine was not turned, unbeknownst to the patient) and placebo tablets. The results obtained in those receiving placebo, either in the form of medication alone, or in connection with simulated diathermy, were approximately as good as those in patients actually receiving treatment. In all cases, about 90 per cent of the patients were symptom free, or substantially improved within four weeks. This certainly implies strong psychogenic factors.

Injuries resulting from prolonged or repetitive postural problems, poor standing or sitting, moving of heavy objects, and physical fatigue resulting from poor lighting or high noise levels, may result in premature onset of degenerative joint disease. Misdiagnosis is very common in osteoarthritis. A patient may present with night pains in the fingers, which are cold and white, and a cervical spine film may reveal some spurring. Often, the physician attributes the symptoms to the roentgenographically demonstrated lesion of the cervical spine, when he should be seeking to diagnose a carpal-tunnel syndrome, or "dead-hand" which is a frequent sequel to work with hand held power tools, such as pneumatic hammers or drills, polishers or buffers.[5]

Rheumatoid arthritis is a potentially crippling disorder, but it can be controlled quite adequately by medical, physical medical, and surgical means in most patients. Nevertheless, secondary gain often leads to failure to respond, magnification or persistence of symptoms out of proportion to physical or laboratory findings, or otherwise unexplainable invalidism. This is particularly profound when the involved area is the cervical spine with a subluxation of the first on the second cervical vertebrae. The residual psychogenic rheumatism in rheumatoid arthritis is not malingering, as it does not represent a conscious attempt by the patient to prolong whatever benefits his illness may have provided. Psychogenic rheumatism is thus probably an element in almost all rheumatic diseases encountered in industry.

For many years, the telephone companies sought to minimize the interscapular and low back pain suffered by the switchboard operator. It was a direct result of the uncomfortable and constrained sitting position an operator had to adopt. The answer was a specially designed and carefully tailored chair which not only gives adequate support, but provides for a slight forward tilt of the pelvis. The original chair constructed for this purpose has been modified since, particularly in regards to the forward tilt of the pelvis achieved with the

low back rest. A more modern chair is now used at the Philadelphia Bell Telephone Company.

Similar pain, such as these workers developed, results from long driving of trucks or automobiles not blessed with power steering. This was once dubbed the "sports car" back or shoulder, a phenomenon that is frequent in individuals who purchase a foreign sports car after having driven an American car (which not only has a higher placement of seats, but also has easier rotation of the wheel). The vibration of a heavy new vehicle also is responsible for low back pain in tractor operators and in truck drivers. Typists and machine operators likewise develop painful spasms of the interscapular muscles.

Lifting of heavy objects, particularly if the patient is unaccustomed to such activity or goes about it clumsily, can lead to a multitude of derangements, the most common of which is the herniation of the nucleus pulposus. Every worker seems to have heard of the "slipped disc." It is amazing how many men suffering from back ailments have never learned to lift weights properly, with knees flexed and back extended, and thus, by bending forward, increase the probability that they will become disabled with each load they hoist.

In the United Kingdom, the most claims for incapacity secondary to arthritis and rheumatism are made by workers in metal, engineering, and related trades. A recent study of 299 foundry workers[6] uncovered a history of rheumatic complaints in 188 of them. Lumbar disc degeneration between the third and fourth lumbar vertebrae accounted for the greater proportion of these, whereas degenerative joint disease unexpectedly was present in but few. However, waiters and others who carry heavy loads are subject to various affections of the shoulders, which may not only be the result of their jobs, but can actively interfere with further work of the same nature.

Though important, transient conditions cannot be totally prevented. However, workers are just as susceptible as anyone else to developing organic rheumatic disease. Obviously, rheumatoid arthritis can be disastrous to the jeweler or the secretary by interfering with finger function. If natural remissions are not forthcoming, and drug induced remissions fail to prevent deformities, functional wrist splints and orthopedic surgery can usually correct the problem sufficiently to permit such patients to return to work. In some, re-training for different types of work may become necessary.

To permit continued working, many physicians prescribe corticosteroids which dramatically relieve the symptoms. Unfortunately, they can ultimately do more harm than good, as not only does the disease progress in the presence of apparent well-being, but these drugs produce many untoward effects. Not the least of these is the posterior subcapsular cataract which, by producing blindness, or unusual diffraction of rays of light, can actually produce more industrial disability than the arthritis for which the corticosteroids were given. Other untoward effects are osteoporosis leading to compression fractures of vertebrae, not only a very painful condition but also an incapacitating one, and aseptic humeral or femoral head necrosis. The aseptic humeral head necrosis is quite similar to the humeral necrosis sustained by sandhogs (tunnel workers) subjected to prolonged periods of elevated atmospheric pressure. Incidentally, the sandhogs and divers also may develop the "bends," named because of acute arthralgias affecting the knees and shoulders, and to a lesser extent, wrists, elbows, and ankles.

Ankylosing spondylitis affects men in their twenties and thirties, predominantly. Though indomethacin (Indocin®)* or phenylbutazone (Butazolidin®)** can effectively treat the symptoms in most patients, and perhaps even control extension of the disease, it may nevertheless be impossible for such patients to continue in jobs requiring heavy labor. Costo-vertebral joint involvement may limit respiratory capacity. Stiffening of even portions of the back may preclude the suppleness necessary. But changing such a patient's employment to a sedentary occupation may not be the answer either. In uncontrolled ankylosing spondylitis, the position most commonly taken by the patient determines the ultimate posture. The sedentary patient develops the hunchback and flexed neck so characteristic of the late disease. The guardsman's rigid back and neck are equally disabling. Strangely, the employment record of patients who have ankylosing spondylitis usually shows less absenteeism, more stoicism in the face of pain and disability, and less superimposed psychogenic factors, than that noted in patients who have other rheumatic diseases.

Paradoxically, the spondylitic may cease working for reasons totally extraneous to the job itself. He may well be able to stand at a workbench, and yet he may be unable to use the toilet because the seat is too low. A detachable elevated toilet seat, readily available, may take care of that problem, yet it is too often overlooked and the spondylitic's real reason for leaving employment may thus never come to light.

In men, degenerative joint changes are rare before the decade of retirement. The spurs of the vertebrae of former athletes who participated in competitive sports are well known. This is illustrated by the case history of a man whose roentgenogram of the neck discloses rather pronounced spurring. In his youth, the patient was a halfback; everytime he was tackled, he was thrown forward on his head, driving his head against his neck; I think this is probably the reason for the advanced spurs at so early an age. In this case, oblique films fail to demonstrate marked encroachment upon the apophyseal joints, so that the disability cannot be explained as "osteoarthritic" alone.

Parenthetically, a discrepancy in the length of the lower extremities produces early degenerative arthritis in the hip of the longer side[7] and in the knee of the shorter. If unrecognized, or treated improperly, these changes can secondarily produce back pain. A form of degenerative joint change that perhaps can legitimately be called osteoarthritis occurs in women in the menopausal decade. The disorder has been variously named: primary generalized osteoarthritis; interphalangeal arthritis, and erosive osteoarthritis, and appears to be on a familial basis in many. It may well be hormonally mediated. Although the hands are affected predominantly, with painful red Heberden's and Bouchard's nodes, first carpo-metacarpal and metacarpophalangeal tenderness and instability, frequently with co-existent Dupuytren's contracture, there are often also similar changes of the cervical spine.

The list of disorders could be expanded almost indefinitely. Despite the prevalence of rheumatic disorders affecting industry, research aiming to alleviate the causes or minimize the

* Merck, Sharp & Dohme.
** Geigy.

sequels has in the main been haphazard and infrequent in this country. It is obvious our medical history training fails to teach us how to discover the conditions of employment of the patient. The expertise of the physician has too infrequently been brought into industry to redesign the working conditions. Treatment of all the enumerated conditions varies, but in all cases begins with a proper history and physical examination. Listening to the patient is perhaps the single most important point, for often the clues not only to diagnosis, but also to proper therapy, lie there (Figure 4). Pills, injections, and physical therapy all have their place, but often postural exercises, positional counseling, or simple bracing and shoe corrections can do more to alleviate the problem than more sophisticated medical measures.

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Pain Syndromes In The Neck, Shoulder And Low Back From A Neurologic Point Of View

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Pain in or arising in the structures of the neck is perhaps the commonest category of complaint in neurologic practice. A large proportion of the adult population will at one time or another seek professional opinion for distress in that area. The pain syndromes in the neck area are divisible into two broad categories: First, those due to pathologic involvement of muscular and ligamentous structures in the neck, and secondly, those due to involvement of the peripheral nerves, nerve roots or the spinal cord.

Before discussing these syndromes specifically, the term osteoarthritis should be dealt with. In recent years the terminology has become clouded so that the term osteoarthritis meaning degenerative or traumatic arthritis, and the term cervical spondylosis overlap. Roentgenographically, the results of osteoarthritis in the neck are: (1) narrowing of the disc space. The intervertebral disc consists of the annulus fibrosis and centrally the nucleus pulposus. With advancing age, as the annulus dessicates and becomes brittle, the nucleus is then more liable to posterior herniation where it may cause symptoms by impinging on the nerve root, the cord proper or the vasculature of the cord. (2) Apophyseal joint sclerosis with narrowing of intervertebral foramina. (3) Posterior spurring and lipping of the vertebra. (4) Increasing cervical kyphosis and anterior subluxation of individual vertebrae. Statistically, 38 per cent of men and 27 per cent of women in the thirty-five to forty-four age group show some x-ray evidence of arthritis or spondylosis of the cervical spine. In the forty-five to fifty-four age group, 67 per cent of men and 65 per cent of women show these changes and in the fifty-five to sixty-four age group the figures are 75 per cent for men and 78 per cent for women. It is therefore not surprising that there is only a marginal correlation between neck symptoms and x-ray evidence of osteoarthritis. Narrowing of the cervical disc space does not necessarily correlate with a ruptured nucleus pulposus, and conversely, integrity of the space does not preclude the nucleus having ruptured and causing symptoms in adjacent neural structures. Similarly, narrowing of neural foramina does not necessarily mean nerve root encroachment. On the other hand, nerve roots may be compressed by a radiolucent cartilage while the foramen appears of normal size on x-ray. Thus, as in other aspects of medicine, correlation between clinical and x-ray findings is essential. A recent patient, a young physician, has unequivocal clinical evidence of ruptured C5-6 disc but has a normal cervical spine. More often, one sees advanced instances of osteoarthritis of the neck in asymptomatic individuals without positive neurologic findings. One hears frequent complaints of middle-aged and elderly patients of snapping and grating of the neck but it is my distinct impression that uncomplicated osteoarthritis of the neck is not often the sole cause of disabling pain. Too frequently, the patient with pain is sent for x-rays and then informed that the pain is due to arthritis. More often than not, the x-ray evidence of osteoarthritis is an incidental finding. This conjures to the patient a picture of gnarled fingers, deformed joints and invalidism.

Cervical discogenic disease is, however, the major cause of neurologic involvement in the neck. Basically, it is a degenerative process and considerably fewer than 50 per cent of such patients can give a history of significant trauma. Discogenic disease occurs most commonly at C5-6, 6-7 and 4-5 in that order of frequency. Not surprisingly, these are the joints with the greatest degree of motility of flexion and extension. One frequently sees extensive osteoarthritis in the necks of those who have led relatively sedentary lives. On the other hand, I recently examined a fifty-year-old professional stock car driver who had a normal cervical spine film after having suffered no fewer than twenty cerebral concussion and neck injuries.

Syndrome of the acute laterally protruded disc may follow acute trauma or strenuous exercise. It is most frequently encountered in the thirty to fifty age group. Pain occurs at the base of the neck with radiation to the trapezius, upper dorsal, paraspinal musculature, medial scapular area and finally into the shoulder, arm and forearm. It is usually relieved by recumbency and characteristically the patient finds some position of head and arm which affords relief. Frequently, numbness and paresthesias restricted

to one or two fingers of the hand give best clue to the level of the disc. Careful and detailed manual motor examination usually reveals isolated motor weakness of which the patient himself is often unaware. Localized fasciculations are not infrequently encountered and one or more of the deep tendon reflexes at the appropriate cervical level are depressed. Sensory loss may be present for only one or two modalities and light touch with cotton is the most sensitive in this regard. The patient experiences pain on active or passive neck extension more so than flexion and pain more often on head and neck turning toward the side of the lesion. Percussion of the vertebral spinous process at the proper level may shoot pain or paresthesias into the hands. Neck and shoulder muscle spasm is often present but usually subsides quickly, once the root pain is eliminated.

The subacute form of protruded disc disease exists in a slightly older age group. Here, there is the same general distribution of pain and other symptoms but motor findings are less striking and the sensory symptoms may involve two or more roots. Here, in addition to mechanical pressure, there is often a vascular component and blood supply to one or more nerve roots is compromised.

Whenever discogenic disease in the cervical area is suspected, a meticulous neurologic examination of the lower extremities should be performed, for myelopathy can occur with either of the above syndromes However, myelopathy due either to mechanical pressure of disc on cord or by impairment of the cord's blood supply, is more often seen in the older age group where posterior ridging or washboard spine compresses the spinal cord at one or more levels or compromises its blood supply. In such instance, neck pain may be minimal and there may be no overt symptoms of root compression in the upper extremities. Here the patient presents with neurologic symptoms in the lower extremities referrable to cord involvement. Whereas there is only a modest correlation between cervical spine films and neurologic involvement, there is a very high degree of correlation between findings on pantopaque myelogram and neurologic localization. In milder cases ambulatory physiotherapy may be possible with out-patient and home traction, hydrocolator packs, ultrasound and massage to the neck and cervical collar. Refractory cases are treated with bedrest and traction. Anterior surgical approach is the treatment of choice for acute laterally protruded discs and posterior laminectomy for spinal cord compression.

Of neck symptoms referrrable to disturbances of soft tissues, there are two types—traumatic and spontaneous. Although the term "hyperextension injury" to the neck is preferred, patients usually employ the more psychically laden term "whiplash." The term implies injury to the muscles and ligamentous structures in the neck and in more severe cases to the spinal ligaments as well. Rear-end collisions are not the only mechanism of injury and forms of hyperextension injury are not rare in civil and industrial accidents as well. Any severe blow to the head will reflect in spasm of the neck muscles, the latter often overshadowed at the time of the more dramatic events of cerebral concussion or contusion. The mechanism is an acute sprain and spasm or tear of the posterior nuchal, trapezius and sometimes the sternomastoid muscles. There follows a vicious cycle of pain and spasm. There is usually seen a relative limitation of neck muscle in all directions. Unlike discogenic disease, there is often more distress on flexion than on extension. The pain may radiate to the shoulders, upper back and parascapular area but seldom to the arms. There is referred pain to the occiput in frontal, retro-orbital area with intermittent or continuous headache and associated symptoms including lightheadedness, occasionally true vertigo, blurred vision, subjective instability in walking, nausea, vomiting and with the severe headaches, occasionally syncope. This group of symptoms bears close resemblance to the postconcussion syndrome, although they may often occur in hyperextension injuries without direct head trauma. When the anterior neck muscles are involved, a pseudoscalenus anticus syndrome results with tingling paresthesias in one or both upper extremities. These paresthesias unlike those of discogenic disease, are more related to recumbency or sedentary posture and are less likely to be restricted to one or two digits. Ancillary studies include neck x-rays and at times, EMG. When discussing x-rays with the patient, it is often unwise to accentuate the presence of arthritis when the symptoms are those of soft tissue involvement. To the patient, arthritis may connote an incurable condition and further increase his anxiety and depression. Electromyography and nerve conduction, when negative, tend to rule out root involvement but as with other laboratory modalities are not without false negatives. In addition to analgesics, medication for muscular and psychic relaxation should be prescribed on a maintenance basis. Formal physiotherapy is of great value. Traction is useful in only a percentage of these patients. The use of a collar is valuable in the acute stages but, like narcotics, must be prescribed with caution, as psychic addiction to the collar may lead to neck weakness. Patients with guarded prognosis are not hard to spot and include: (1) individuals concerned more with the litigious aspects than with the medical problem, (2) dependent individuals in whom incapacitation satisfies their dependency needs, (3) individuals with previous history of tension type headaches, psychoneurotic trends or inordinately prolonged convalescences, (4) when in the course of a complete neurologic examination, hysterical sensory deficits are encountered.

A very large group of patients develop symptoms akin to whiplash with minimal or no history of trauma. Symptomatically, they are otherwise indistinguishable except that they are more likely to be concerned with the headache symptoms and are sometimes even unaware that the headache originates from spasm in the neck muscles. These may vary from cases of acute torticollis to prolonged periods of unrelenting headache of migraine severity. The term fibrositis is often appropriate here. These individuals may show rigid and compulsive personality traits and history of tension headache and periodic muscle spasm going back into adolescence with family history of the same. Often poor posture is present or the patient's occupation requires a bent forward posture such as over a desk, drawing board or machinery. Others give history of easy fatigability and pain and cramps in the low back and anterior chest wall syndrome. Here, psychic trauma, exposure to draft or fatigue may set off stiff painful neck which is then perpetuated by a vicious cycle or anxiety, spasm and pain. A meticulous and detailed examination is usually helpful here in persuading the patient that he is free of neurologic deficit. With these patients, I have found useful a highly structured daily program involving home phy-

siotherapy with application of hot, moist compresses to the neck and shoulders, followed by range of motion exercises and massage. This is supplemented wih psychic relaxants and analgesics as needed.

Other Causes Of Neck And Shoulder Pain

Bursitis does not usually present a difficult differential diagnosis. In the presence of localized pain in the deltoid area, limitation of abduction in the extremity and the absence of positive motor or sensory neurologic findings, the diagnosis is relatively easy.

Thoracic Outlet Syndrome—cervical rib, is not so fashionable a diagnosis as it once was. There are cases, however, in which shoulder pain, arm paresthesia and cyanosis may be dramatically relieved by surgery. Similarly, scalenotomy may give dramatic relief in clear cut cases of scalenus anticus syndrome as confirmed by a definitely positive Adson's maneuver and associated with aberrant or hyperthrophied scalenus muscle. However, where symptoms are an overflow of the more generalized tension fibrositis of the neck and shoulders, the results of surgery are considerably less gratifying.

Cord tumors in the cervical area are not rare and may cause radicular pain. Positive signs of root involvement and early cord symptoms usually prompt early investigation with myelogram and appropriate diagnostic studies.

Neuralgic Amyotrophy is caused by a neuratrophic virus with a special predilection for the upper cord of the brachial plexus. It is by no means rare and occurs sporadically and in small epidemics. Initially described by the English neurologists, Turner, Parsonage and Spillane, it is a disease which has received relatively scant attention in this country. It is a self-limiting illness of four to eight weeks characterized by very severe neck, shoulder and arm pain quite akin to acute laterally protruded disc. There is usually marked atrophy of isolated and proximal muscles, especially of the serratus anterior, which is rarely involved in discogenic disease. The sufferer, unlike the disc patient, is unable to find a position of comfort and myelogram is negative.

Angina may present as neck pain alone. One patient had posterior neck pain at C6 level with exertion and bilateral arm radiation with sustained exertion. For two years this patient was erroneously treated as a cervical disc.

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Low Back Pain

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I will limit my discussion to what I have chosen to term "industrial backache." This can be produced by acute, subacute, or chronic trauma. It can be as dramatic as falling down a flight of stairs, or as insidious as sitting in a chair.

I would like to discuss the mechanics of the lumbosacral mechanism and I would like to focus your attention on 95 per cent of the cases. This will automatically restrict our discussion to 5 per cent of causes. I am leaving out metastic disease; I am leaving out metabolic disease; I am leaving out infection; and I am leaving out primary tumors of bone and spinal cord.

I will discuss acute low back strain and chronic back strain which can be subdivided into unresolved acute low back strain, lumbosacral instability, and degenerative arthritis. I will also discuss the acute herniated disc.

The lumbar lordotic curve is very important to posture and is maintained by muscle, tendon, ligament, capsule, and skeletal architecture. Maximizing or minimizing this curve may produce symptoms. Maximizing or exaggerating the lumbar curve is commonly seen in acute injury with associated muscle spasm. The exaggerated curve converts the normal compressive force of contiguous vertebrae to a shearing force which is most severe across the lumbosacral vertebrae. Minimizing or flattening the lumbar curve is frequently associated with degenerative arthritis, and while most of the force is of a compressive nature, the degenerative changes and stiffness account for symptoms. Proper posture requires a normal lumbar lordotic curve. Too much or too little curve is detrimental and can be symptomatic.

We are constructed with balanced curves, but with backache, with an acute strain (and I shall try to define this in a moment) the muscles go into spasm; the large para-lumbar muscles, posterior to the spinous processes and adjacent to them, will go into spasm and increase this curve. Once this curve is increased, it is maintained for a period of time until the pain subsides.

If the acute injury is transient, the curve will correct itself spontaneously. If this acute strain lasts for a number of weeks, secondary contractural changes will set in. Then, after the pain has long since gone, the spine will continue to have an exaggerated lumbar curve.

A strain or sprain is a partial disruption of muscle fiber or ligament. It is most notably evident where a muscle or ligament attaches to bone through the periosteum.

When a person injures his back, he will have either immediate or delayed onset of pain. Immediate pain is also related to a tearing or disruption of the periosteum which is richly innervated with sensory fibers. If the periosteum is stripped up but not torn from the bone, bleeding or hemorrhages occur between the bone and the periosteum. This produces distension of the periosteum, and the late onset of pain. The patient with a delayed onset and an acute backache can have dramatic relief following manipulation or Procaine infiltration, because with the kneading and massage of the hematoma, the periosteum is decompressed and the pain is alleviated. Not so if the same maneuver is attempted weeks later. This will only occur if it is done early in the course of the disability.

Most acute low back strains subside promptly with rest and medication. Residual contracture should be promptly treated by remedial exercise to restore mobility and proper posture.

Chronic low back strain is most

commonly brought on by the unresolved acute back injury. Typically, it is an individual who had a severe injury, was treated either with rest, medication, or both for a period of time until he felt well enough to return to work. Thereafter, he complains of a nagging backache. This is the pain that will come on after he has driven fifty miles in a truck or sat four hours at a desk. This is the pain of fatigue. The individual may forget the acute injury; now all he knows is that he has recurring low back pain that is related to activity associated with stiffness. The disability is related to this exaggerated lumbar curve brought on by the injury. These patients usually do not have too much pain if they are well rested, but as the day goes on and the muscles fatigue, the ligaments in the lumbar area then have to take up the slack to maintain the exaggerated lumbar curve. This is associated with a dragging, aching backache.

A physician can readily rectify the problem by prescribing flexion exercises for two weeks. Stretch out this lumbar curve, allow this mechanically unsound situation to come into balance, and the pain will be relieved.

Lumbosacral instability can also cause chronic low back strain. Spondylolisthesis, spondylolysis, and spina bifida occulta are the most common causes that are evident on the roentgenogram. There are other causes which are subtle and difficult to diagnose. There are all degrees of instability and some of the more severe forms produce symptoms in the second decade while others may be asymptomatic for life.

Characteristically, when an individual with an unstable lumbosacral mechanism injures his back, it is usually months and frequently years before the situation is relieved. It is also common for these individuals to have frequent relapses from trivial injury.

The initial treatment of these individuals is with rest, medication, braces, and remedial exercises. If a remission can be produced, guarded activity and a specific exercise program should be continued indefinitely. If the patient continues to have significant disability, then a thorough reappraisal for definitive care is indicated. When a young person continues to have recurring disability, serious consideration should be given to a spinal fusion. It is very difficult to generalize about treatment because no two patients have identical problems. The treatment has to be tailored to the specific need, age, and disposition of the individual.

Another cause of chronic low back pain is osteoarthritis, and this comes in many forms. There is the individual who falls off a "dolly" at nineteen years of age, fractures a lumbosacral facet, and has localized post traumatic osteoarthritis. At the other extreme is the sixty-year-old bricklayer who has been working in a semi-bent position all his life. In one instance, it is an acute traumatic episode that has produced localized osteoarthritis, in the other, it is the wear and tear of use and abuse.

Now in the young individual facing a life of work and the likelihood of recurring disability, one would be disposed to stabilize the painful segment, relieve the pain, and try to bring this to an early successful conclusion. In the older individual, a much more conservative approach would be indicated, such as rest, heat, analgesics, anti-inflammatory drugs, and support.

An osteoarthritic joint is an inflamed joint. It has two articular surfaces that are roughened and irregular. Excessive motion or exercise would be irritating to the surrounding soft structures and is therefore contraindicated. This individual complains of stiffness and aching in the morning, relief with some activity, aggravation toward the end of the day, and exacerbation with inclement weather or abuse. The elderly individual with this form of arthritis is usually treated with a brace.

Herniated lumbar discs can be divided into two types depending on whether or not the annulus is ruptured. The protruded disc has an intact and bulging annulus. It represents about 90 per cent of herniated discs. The extruded disc has a ruptured annulus and constitutes the remaining 10 per cent of cases. Both types of discs can present with similar symptoms, namely backache and sciatica. The majority of protruded discs respond to conservative care. Appropriate follow-up care for 12-18 months can result in a lasting remission in 80 per cent of cases. The 20 per cent of protruded discs that do not respond and continue to demonstrate positive neurologic findings require surgical excision. An extruded disc will rarely respond to conservative measures and almost routinely require excision.

Two weeks of complete bed rest with appropriate medication is usually an adequate period of time to determine the future course of therapy. If symptoms and objective findings are remitting, then further conservative care is indicated. If the patient continues to have significant pain and a neurologic defect, then surgery should be considered. It is at this juncture that myelography is indicated, not to make the diagnosis but to localize the lesion. I do not feel that these patients should be indiscriminately fused. The majority of these patients are eminently treated by conservative care. There is a lesser number that require disc excision and a far smaller number that will require lumbosacral fusion.

John L. Sbarbaro, M.D., assistant professor of orthopedic surgery, University of Pennsylvania School of Medicine, Philadelphia.

RHEUMATIC DISEASES IN INDUSTRY—SUMMARY OF ARTICLES

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Introduction: Mildred C. J. Pfeiffer, M.D., M.P.H.
What Arthritis Costs You: Allan M. Wolfe, M.D.
Personal Attitudes and Motivation: B. Berthold Wolff, Ph.D.
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PENNSYLVANIA MEDICINE cardiovascular briefs

Emotional Factors in Cardiovascular Disease

Part I

■ **William G. Leaman, Jr., M.D. questions Abraham J. Twerski, M.D., Clinical Director, Department of Psychiatry, St. Francis General Hospital, Pittsburgh, Pennsylvania.**

"For every passion of the mind which troubles mens' spirits, either with grief, joy, hope, or anxiety, and gets accesse to the heart, there makes it to change from its naturall constitution, by distemperature, pulsation, and the rest, that infecting all the nourishment, and weakening the strength, it ought not at all to seem wonderfull if it afterwards begets divers sorts of incurable diseases . . ."
William Harvey, De Motu Cordis, 1628

What types of cardiovascular diseases may be related to emotional factors?

Emotional factors may influence any type of cardiovascular disease, directly or indirectly. For example, obesity resulting from compulsive eating affects the cardiovascular system, and a patient with rheumatic heart disease may have self-destructive drives resulting in indiscretions in effort, or neglect of proper medication. However, we generally think of arteriosclerotic heart disease, myocardial infarction, and essential hypertension as being more immediately related to psychogenic factors.

Are emotional disorders capable of causing heart disease?

It is virtually meaningless to speak of *a* cause of any illness. Disease is almost always the result of the interplay of a number of factors, which, *taken together*, constitute the cause. In this sense, emotional reactions can be important contributing factors.

Do emotional factors contribute to cardiovascular disease?

Let us talk of emotional *reactions* rather than "disorders." It is hardly a "disorder" for a person to experience intense fear in the face of danger, or rage in case of an insult. Yet the physiologic changes in fear and rage, i.e., increase in the heart rate, stroke volume, and blood presure, bring about an increase in the cardiac load. Under stress there is an acceleration of blood coagulation time and a rise in the serum cholesterol. Both of these have been suspected in the pathogenesis of arteriosclerotic heart disease and myocardial infarction.

Are instances of fear and rage sufficient to bring about physiologic malfunction in an otherwise healthy system?

Probably not. However, physiologic changes similar to those of fright can occur when there is no evident danger. The individual may feel this as *anxiety*, which is simply a fear reaction in absence of objective danger. Similarly, the bodily adaptation to rage may occur although the person has not had an explosive outburst, but has "buried" his anger within himself. An individual with deep-seated feelings of insecurity may suffer from chronic anxiety, and the withdrawn, passive individual may harbor chronic rage. These prolonged reactions, which may not be evident on the surface, may provide a persistent stress on the cardiovascular system.

Are there specific personality types that are prone to develop cardiovascular disease?

A patient who readily expresses his anger when provoked appears superficially to be more "emotional," yet one who appears to be more tranquil may be seething with fury which he is afraid to express. It is the inner psychological structure which is significant, rather than what we are prone to classify as "personality types" based on observable behavior.

Are there any professions or vocations which predispose to cardiovascular disease?

Occupation is of less importance than an individual's attitude toward his work. The common denominator of psychogenic factors in the etiology of cardiovascular disease is generally mounting tension of prolonged duration, which may result from the stresses of domestic, social or interpersonal situations as well as from occupational stress.

What role do emotions have in precipitating a cardiovascular crisis?

A damaged, but compensated, cardiovascular system can become decompensated by a sudden increase in work load, such as occurs in a stress reaction. This is of extreme importance, with the initiation of a dangerous vicious cycle, since the pain, dyspnea, and other sensations resulting from an attack cause severe anxiety, which then increases the burden on the cardiovascular system, thus further aggravating the decompensation and symptoms, producing more anxiety, etc.

If anxiety is so great a factor in precipitating cardiovascular attacks, why does myocardial infarction occur so often during sleep?

Although anxiety is *a* precipitating factor, it is certainly not the *only* precipitant. It is erroneous to equate physical rest or even sleep with freedom from strain. The common phenomenon of a "nightmare" indicates that there may be intense anxiety even during sleep.

■ **William G. Leaman, Jr., M.D. edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.**

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Indication—Oral contraceptian.

Contraindications—Thrambaphlebitis, thrambaembolic disarders, cerebral apaplexy ar a past history af these canditians, markedly impaired liver functian, knawn ar suspected carcinama af the breast, knawn ar suspected estragen-dependent neaplasia, undiagnased abnarmal genital bleeding.

Warnings—Watch far the earliest manifestatians af thrambatic disarders (thrambaphlebitis, cerebravascular disarders, pulmanary embalism, retinal thrambasis); if present ar suspected discantinue the drug immediately.

British studies reparted in April 1968[1,2] estimate there is a seven- ta tenfald increase in martality and marbidity due ta thrambaembalic diseases in wamen taking aral cantraceptives. In these cantralled retraspective studies, invalving 36 reparted deaths and 58 haspitalizatians due ta "idiapathic" thrambaembalism, statistical evaluatian indicated that the differences abserved between users and nan-users were highly significant. The canclusians reached in the studies are summarized in the table belaw:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users af Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

Na camparable studies are yet available in the United States. The British data, especially as they indicate the magnitude af the increased risk ta the individual patient, cannat be applied directly ta wamen in ather cauntries in which the incidences af spantaneausly accurring thrambaembalic disease may differ.

Discantinue medicatian pending examinatian if there is sudden partial ar camplete loss af vision, ar sudden anset af praptosis, diplapia ar migraine. Withdraw medicatian if papilledema ar retinal vascular lesians are found.

Since the safety of Ovulen in pregnancy has not been demanstrated, it is recammended that pregnancy be ruled out far any patient who has missed two consecutive periods before cantinuing the cantraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction af the harmone agents in oral cantraceptives has been identified in the milk af mathers receiving these drugs. The lang-range effect an the nursing infant cannat be determined at this time.

Precautions—Pretreatment physical examinatian shauld include special reference ta the breasts and pelvic argans, and a Papanicolaau smear.

Endacrine and passibly liver functian tests may be affected by Ovulen. Therefare, it is recammended that such tests if abnarmal be repeated after the drug has been withdrawn far twa manths.

Pre-existing uterine fibramyamas may increase in size under the influence af pragestagen-estragen preparatians.

Because these agents may cause same degree af fluid retentian, canditians which might be influenced by this factar, such as epilepsy, migraine, asthma, cardiac ar renal dysfunctian, require careful abservation.

In breakthraugh bleeding, and all irregular vaginal bleeding, cansider nanfunctianal causes. Adequate diagnastic measures are indicated in undiagnased vaginal bleeding.

Carefully abserve patients with a histary af psychic depressian and discantinue the drug if severe depressian recurs.

Any passible influence af pralanged Ovulen therapy an pituitary, avarian, adrenal, hepatic ar uterine functian awaits further study.

A decrease in glucase talerance has accurred in a significant percentage af patients an aral cantraceptives. The mechanism af this decrease is abscure. Far this reasan, diabetic patients shauld be abserved carefully while receiving Ovulen.

Because af the effects af estragens an epiphyseal clasure Ovulen shauld be used judiciausly in yaung patients in wham bane growth is nat complete.

The age af the patient canstitutes na absalute limiting factar, althaugh Ovulen therapy may mask the anset af the climacteric.

The pathalagist shauld be infarmed af Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant assaciatian has been shawn between use af aral cantraceptives and the fallawing seriaus adverse reactians: thrambaphlebitis, pulmanary embalism.

Althaugh available evidence is suggestive af an assaciatian, such a relatianship has been neither canfirmed nar refuted far the fallawing seriaus adverse reactians: cerebravascular accidents, neura-acular lesians, e.g., retinal thrambasis and aptic neuritis.

The fallawing adverse reactians are knawn ta accur in patients receiving aral cantraceptives: nausea, vamiting, gastraintestinal symptams (such as abdaminal cramps and blaating), breakthraugh bleeding, spatting, change in menstrual flaw, amenarrhea during and after treatment, edema, chlaasma ar melasma, breast changes (tenderness, enlargement, secretian), change in weight, changes in cervical erasian and cervical secretians, suppressian af lactatian when given immediately past partum, chalestatic jaundice, migraine, allergic rash, rise in blaad pressure in susceptible individuals, mental depressian.

Althaugh the fallawing adverse reactians have been reparted in users af aral cantraceptives, an assaciatian has been neither canfirmed nar refuted: anavulatian post treatment, premenstrual-like syndrame, changes in libida, changes in appetite, cystitis-like syndrame, headache, nervausness, dizziness, fatigue, backache, hirsutism, loss af scalp hair, erythema multifarme and nodasum, hemarrhagic eruptian, itching. The fallawing labaratary results may be altered by aral contraceptives: hepatic functian: increased sulfabromophthalein and other tests; coagulatian tests: increase in prothrombin, Factars VII, VIII, IX and X; thyraid functian: increase in PBI and butanal extractable protein baund iodine, and decrease in T^3 uptake values; metyrapone test; pregnanedial determinatian.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

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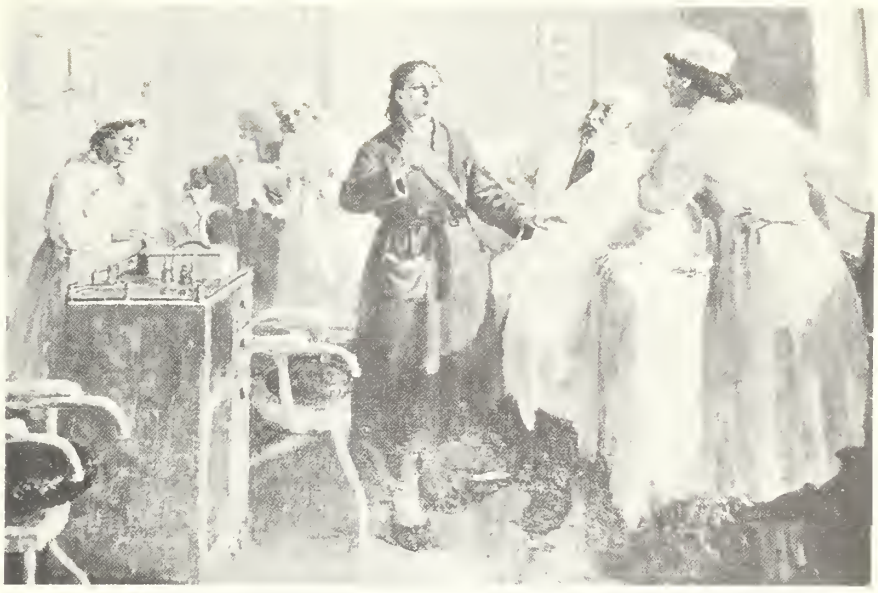
Ophthalmic medicine in the Union of Soviet Socialist Republics is of the highest quality and is in many areas comparable to ophthalmology in the United States, but in our country, greater strides have been made in therapeutics.

In the Soviet Union there is a deep devotion to the prevention of blindness and the restoration of sight. This dedication is institutionalized at the Helmholtz Eye Institute in Moscow, under the direction of the late Dr. Alexander Roslotsev, an outstanding physician and scientist, and at the Filatov Eye Institute in Odessa on the Black Sea, which operates under the direction of a fine woman physician, Dr. Nadegda Puchkovskaya. Women make up 85 per cent of the staff at these two institutions.

The greatest figure in Soviet ophthalmology was the late Vladimir Filatov, whose major contribution was in the field of corneal transplantation. It will be recalled, corneal transplantation was successfully performed by Von Hipple in 1906, Zirm and Elschnig in 1908. Filatov, first began corneal grafting in 1912 but World War One interrupted his work and he resumed



Soviet ophthalmology, 50 years old—*The above oil painting glorifies one of the early successful corneal transplants in Soviet ophthalmology by Vladimir Filatov (1875-1956), whose major contributions were in the field of transplantation. The oil painting which hangs in the Filatov Institute in Odessa, was photographed by Milton J. Freiwald, M.D., during his stay there as the American representative to the first medical exchange program in ophthalmology, surgery and research between the United States and the U.S.S.R., sponsored by the Office of International Health, Department of Health, Education, and Welfare of the United States.*

How the U.S.S.R. and the United States Compare in Eye Care

MILTON J. FREIWALD, M.D.
Philadelphia

studies in 1922. By 1949 he had performed some 1,000 transplants and by 1955 he and his co-workers had performed some 3,500 corneal operations. This work is extremely significant, when one considers the statistics. Some 35 per cent of all causes of blindness are due to leucoma (corneal scarring) which prevents the image carrying rays of light from entering the perceptive retina and then back to area seventeen of the brain.

Figure One shows a superior fornix base conjunctival flap—a simplified method to cover the transplant and thus prevent it from slipping out of place. Corneal transplant surgery is continued by such Filatov proteges as Drs. Puchkovskaya, David Bushmich and Vladimir Shevelev.

In the field of retinal separation surgery, Dr. Vladimir Shevelev is one of the leaders in the Soviet Union. Surgical repair is similar to our methods. Their successes and failures are somewhat similar—for it must be remembered the results of retinal repair in separation will depend on several factors: The location of the separation and tear, the extent of the separation and severity of degenerative changes setting in, prior to the patient's coming for aid and the duration of time elapsed from onset of the retinal damage. An unfavorable location will yield no dramatic recovery regardless of the surgical skill or method.

Dr. Shevelev, working on his own, has also worked out a rerouting of Stenson's Duct to the fornix conjunctiva for the substitution of parotid gland secretion for tears in cases of lacrimal gland deficiency. To my knowledge, this has never been duplicated. See Figure Two.

Soviet physicians have devised a number of special instruments. I was particularly impressed with their corneal-scleral suture stapler, which may save time and reduce complications in the healing of incisional wounds. This stapler is a smaller version of a stapler developed in the U.S.S.R. for use in thoracic and abdominal surgery.

Cryo-surgery for cataract extraction, which, of course, was pioneered and brought to fruition by Krwawitz of Lublin, Poland, is used in the U.S.S.R. The late Dr. Roslotsev, gave me the instrument, then used with methyl alcohol and CO2 for the desired hypothermia and mentioned to me at the time that he believed this method would one day prove to be the safest method for cataract extraction. How true was his prediction. The most modern apparatus for use in cryo-surgery has, however, been perfected in the United States. We are indebted to John Bellows, M.D., of Chicago for his efforts in this field as well as Kelman of New York and others.

It is well to recall my esteemed friends, the late Temple Fay M.D. and his protege, Henry T. Wycis, M.D.,

neuro-surgeons of Temple University Medical Center, who pioneered in the freezing methods in neurosurgery and and whose names are by no means strange to the Soviet scientists. Dr. Wycis first induced hypothermia in three critical cases of cerebral trauma successfully in 1946.

As for glaucoma surgery, it is about as successful in the Soviet Union as elsewhere, with the closed angle type usually managed by surgery; while the open angle cases are predominently managed medically.

For determining refractive formulae, when dealing with large numbers of patients at the Filatov Institute, Dr. Irene Kluka uses an ingenious machine which, by manipulations of dials gives the formula quickly and accurately. I recall seeing a similar apparatus, when I studied in London, but it was seldom used.

The understanding of the broad subject of neuro-ophthalmology is well known to Soviet specialists as elsewhere and the mechanisms of the physio-pathologic aspects of Strabismus and its surgical corrections are well known.

In the realm of therapeutic management however, the gap between westtern and Soviet ophthalmology is somewhat wider. For instance, "tissue therapy" is used in the U.S.S.R. to treat ocular inflammatory disease. This consists of subcutaneous and intramuscular injections of distillates of such substances as lagoon mud containing microscopic flora and fauna, aloe leaves and beet and placenta extracts. Macerated skin, at first human and later animal, are also injected beneath the skin of the patient.

Tissue therapy according to the teaching of Filatov, is based on the belief that these substances are rich in biogenic stimulation which promotes healing of diseased Uveal, Retinal and Optic nerve tracts. It is also claimed these methods cure Retinitis Pigmentosa. I do not recall any significant intra-ocular disease cured with these methods. There appears to be no specific scientific basis for this method of therapy.

Leeches are still used for treating ocular disease as well as traumatic problems. It is worthy to mention, however, that when the leech sucks blood, a substance called hirudin, an anti-coagulant, is secreted into the wound.

It appears from observation that in medical management the United States is more advaned, and has a number of pharmaceutical products, including antibiotics and steroids, which increase the opportunity for successful medical management. The introduction of steroid therapy in the cure of Herpes Zoster Ophthalmicus was accepted with great acclaim by Soviet physicians, as was the use of Stoxil * in the curative therapy of Dendritic ulcer of the cornea in Herpes Simplex.

The free exchange of medical thinking between the U.S.S.R. and our country permitted the visit to be most rewarding.

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* Smith, Kline & French Laboratories

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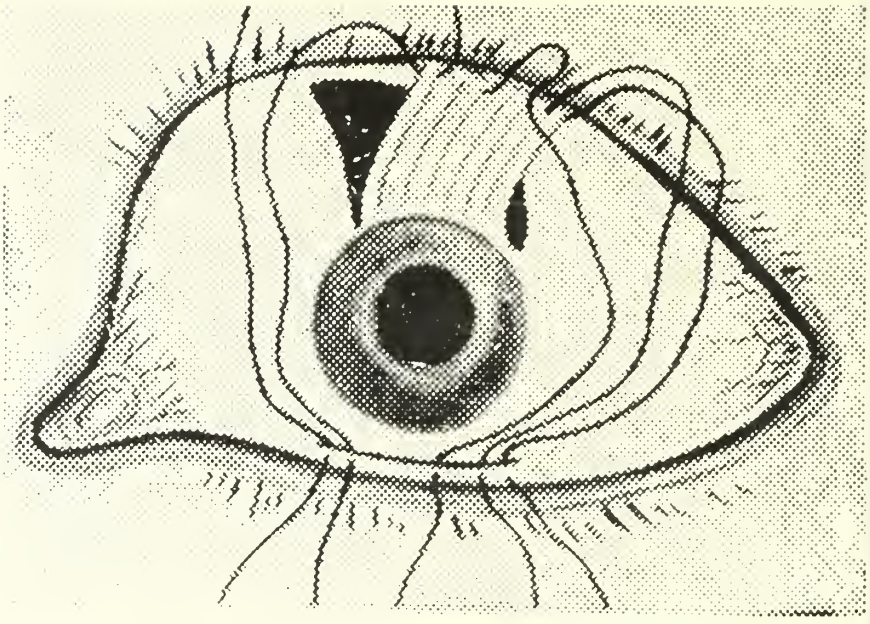
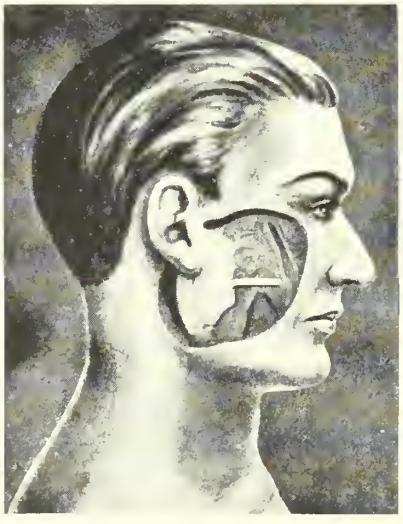


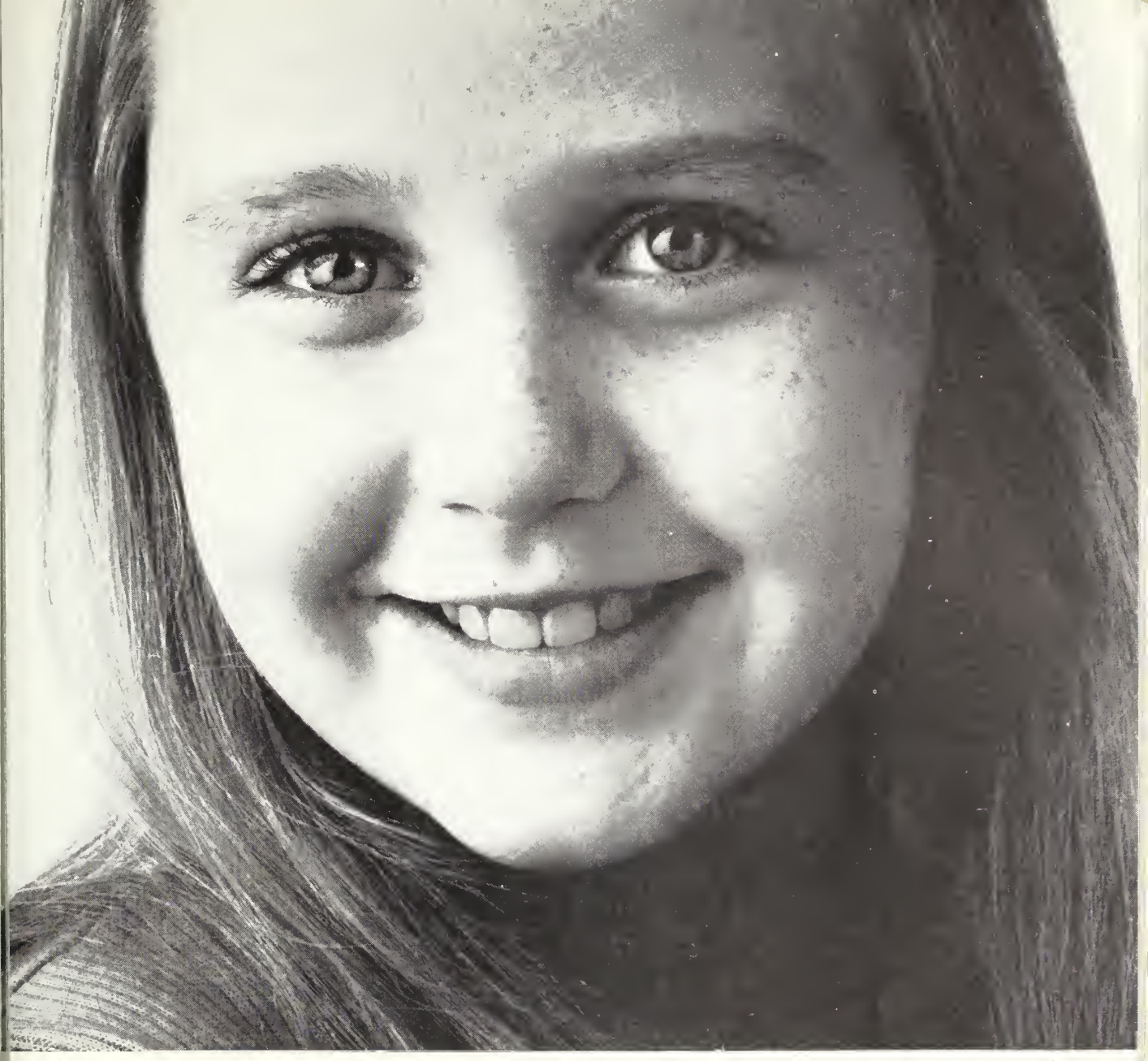
Figure One

Here is shown a superior fornix base conjunctival flap, a simplified method to cover the transplant and thus prevent it from slipping out of place.

Figure Two

The duct of Steno is shown left in its normal position, and right after transposition.





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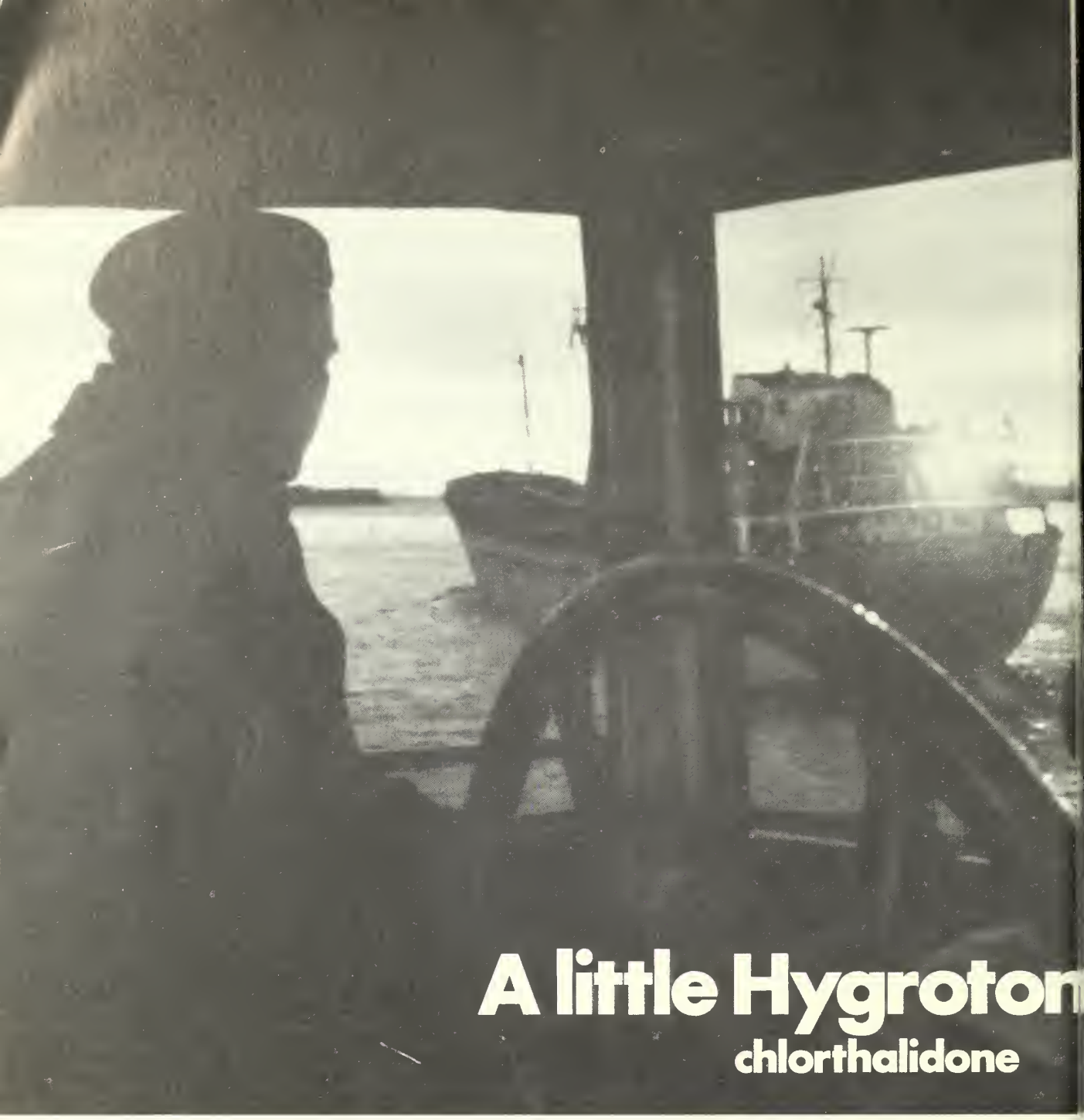

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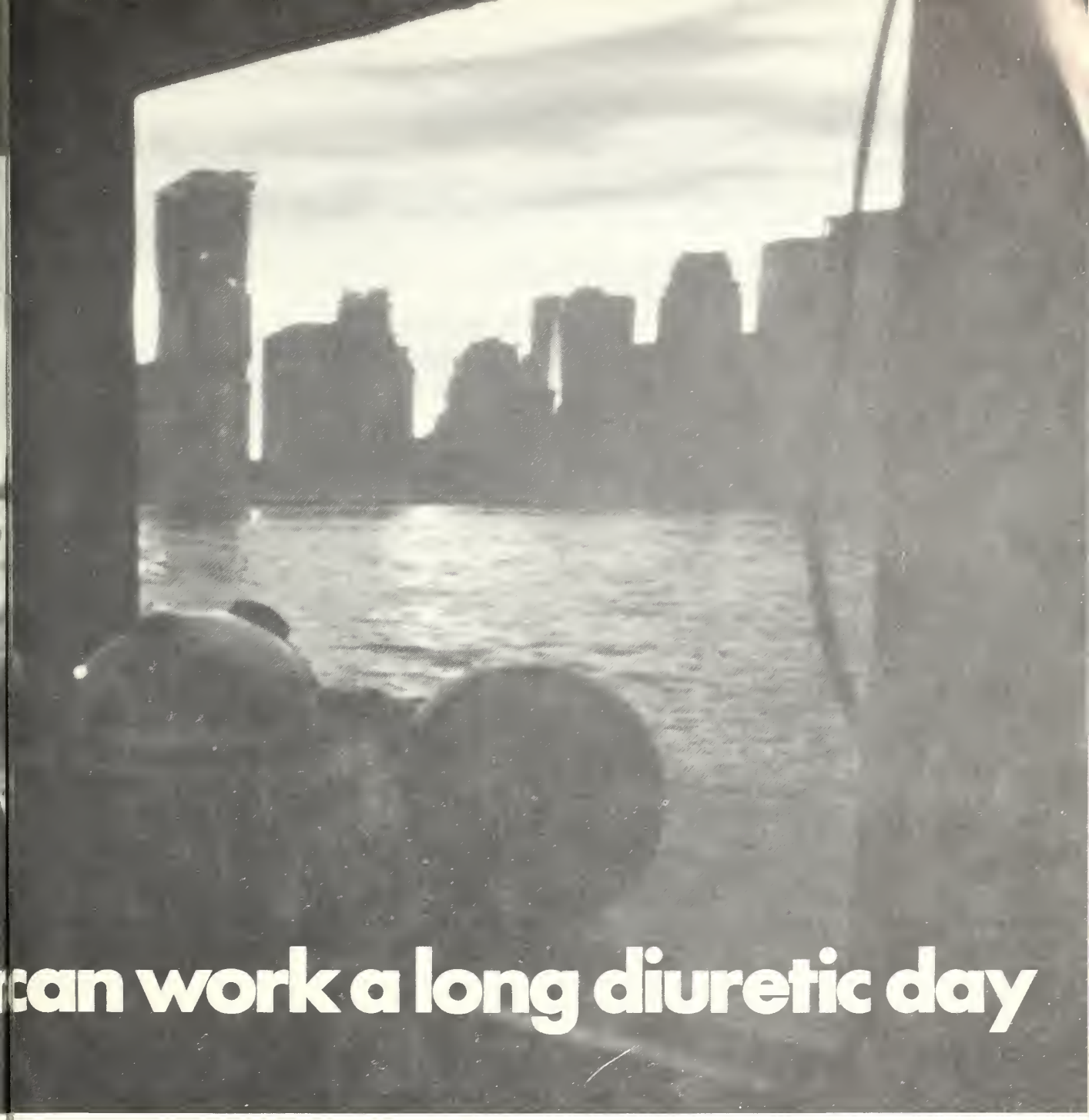

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Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepotic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

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Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

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continuing education

A list of educational opportunities offered to physicians in the interest of maintaining their competence and skill. Unless otherwise indicated, all courses are designed for physicians engaged in primary patient care.

CARDIOVASCULAR DISEASE

July 9, 1969; Pittsburgh

C—**Cardiopulmonary Resuscitation Instructors' Training Course;** by Pa. Heart Assoc., at Pitt; 8 hrs. AAGP credit; $15 fee. Contact any Heart Association.

July 14-18, 1969; Philadelphia

C/AMA—**Interpretation of Cardiac Arrhythmias;** by Hahnemann, at Marriott Motor Hotel; 40 hrs. AAGP credit applied for. $150 fee. Contact Leonard S. Dreifus, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

CHEST DISEASES

September *24-26*, *1969*; Cleveland, Ohio

C/S—**Clinical application of Pulmonary Physiology (The Cleveland Course in Pulmonary Diseases);** by Case Western Reserve Univ., at St. Luke's Hosp. Fee $100 ($75-Amer. Thoracic Society members). Contact Joseph M. Foley, M.D., Continuing Med. Educ., Case Western Reserve, 2107 Adelbert Rd., Cleveland 44106.

November 10-21, 1969; Philadelphia (Repeat February 9-20, 1970 and April 6-17, 1970)

PG/AMA—**Postgraduate Course in Bronchoesophagology;** at Temple; for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. $350 fee. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

ELECTROCARDIOGRAPHY

July 7-11, 1969; Philadelphia

C/AMA—**Clinical Electrocardiographic Interpretation;** by Hahnemann, at Marriott Motor Hotel; 40 hrs. AAGP Credit applied for. $100 fee. Contact Leonard S. Dreifus, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

July 14-15, 1969; Philadelphia

C/AMA—**Complex Electrocardiographic Problems;** by Hahnemann at Marriott Motor Hotel; 14 hrs. AAGP credit applied for. $100 fee. Contact Leonard S. Dreifus, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

ENDOCRINOLOGY

January-May, 1970 (3rd Thurs. ea. mo.); Bethlehem

I—**Endrocrinology: Medical and Surgical Aspects;** at St. Luke's Hosp., by Jefferson; 24 hrs. AAGP credit; $24 fee (6 seminars), $7 ea. Contact Michael L. Sheppeck, M.D., Med. Dir., St. Luke's Hospital, Bethlehem 18015.

"CODE KEY"

C—Consecutive days
I—Intermittent
O—Circuit
PG—Postgraduate Traineeship
R—Radio
TV—Television
S—Designed for full-time specialists
AMA—AMA Accredited Institution
C E S—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Penn-Grad—University of Pennsylvania, Division of Graduate Medicine
Pitt—University of Pittsburgh School of Medicine
Pitt P.H.—University of Pittshurgh Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania School of Medicine
Woman's—Woman's Medical College of Pennsylvania

GENERAL MEDICINE

Every Thursday; Hazleton State General Hospital

I—**Program of Continuing Medical Education by Hazleton Branch. Luzerne County Medical Society.** Contact Robert Gunderson, M.D., Suite 412 Northeastern Building, Hazleton, Pa. 18201.

September, 1969-May, 1970; Philadelphia

PG—**Retraining Program for Women Physicians;** at Woman's; 6 hrs. a day, 3 days a week, 35 weeks, no fee. Contact Ethel Weinberg, M.D., Woman's 3300 Henry Ave., Philadelphia 19129.

September 4, 1969; Pottsville Hospital

I/AMA—**Clinical Implications of Newly Discovered Hormonal Agents** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

September 12, 1969—Williamsport Hospital

I/AMA—**Fevers of Unknown Origin in a Pediatric Population** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP Credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

September 15-18, 1969; Lancaster

C—**"Clinical Therapeutics—1969";** by C E S; at Host Farm Resort Motel. Fee: $10. Contact John H. Killough, M.D., PMS—Taylor Bypass and Erford Rd., Lemoyne 17043.

October 2, 1969; Pottsville Hospital

I/AMA—**Preoperative Evaluation to Prevent Postoperative Complications** (Progam of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 2, 1969; Altoona Hospital

I/AMA—**Obstetric and Gynecologic Endocrinology** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 10, 1969; Williamsport Hospital

I/AMA—**Hepatitis;** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 15, 1969-December 3, 1969 (Wednesdays); Philadelphia

I/AMA—**Recent Advances in Medicine;** at Temple; 32 hrs. AAGP Credit; $50 fee. Contact Albert J. Finestone, M.D., Dept. of Med., Temple, Broad & Tioga Sts., Phila. 19140.

October 16, 1969; Altoona Hospital

I/AMA—**Hepatitis, Consecutive Case Conference** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

November 2, 1969; Philadelphia

C—**Third Annual J. Herbert Nagler Memorial Symposium;** by Philadelphia Academy of G.P.; at Holiday Inn; $10 fee; 6 hrs. AAGP credit. Contact Milton W. Perloff, M.D., 2923 W. Cheltenham Ave., Philadelphia 19150.

November 6, 1969; Pottsville Hospital

I/AMA—**When to Operate for Hypertension** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

continuing education

November 6, 1969; Altoona Hospital

I/AMA—**Medical and Surgical Approaches to Inflammatory Lesions of the Colon** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 14, 1969; Williamsport Hospital

I/AMA—**Hormonal Contraceptives—Indications and Contraindications** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 20, 1969; Altoona Hospital

I/AMA—**Myocardial Infarction, Consecutive Case Conference** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 4, 1969; Altoona Hospital

I/AMA—**Innocent Murmurs in Children;** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 4, 1969; Pottsville Hospital

I/AMA—**The Pill—More Than the Answer to a Maiden's Prayer** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 9-12, 1969; Philadelphia

C/AMA—**Emergencies in Medical Care;** by Hahnemann; at Marriott Motor Hotel; 56 hrs. AAGP credit applied for; $150 fee—paramedics $35. Contact Stanley Spitzer, M.D. or Wilbur W. Oaks, M.D., Hahnemann, 230 North Broad St., Philadelphia 19102.

December 12, 1969; Williamsport Hospital

I/AMA—**Current Concepts of Thyroid Disease;** (Program of Continuing Medical Education—2nd Thurs. of each month) by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Altoona Hospital

I/AMA—**Approach to the Patient with Fever of Unknown Origin** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

January 8, 1970; Pottsville Hospital

I/AMA—**Chronic Leg Ulcers** (Program of Continuing Medical Education—1st Thursday Each Month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

January 15, 1970; Altoona Hospital

I/AMA—**Newer Diagnosis Techniques in Radiology** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

February 5, 1970; Pottsville Hospital

I/AMA—**Hepatitis** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 5, 1970; Altoona Hospital

I/AMA—**Current Theories Concerning Causation of Cancer** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

February 13, 1970; Williamsport Hospital

I/AMA—**Surgical Aspects of Venous and Arterial Insufficiency of the Lower Extremities** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Altoona Hospital

I/AMA—**Hyperlipodemias** (Program of Continuing Medical Education—twice a month by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

March 5, 1970; Pottsville Hospital

I/AMA—**Infections of the Central Nervous System** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 5, 1970; Altoona Hospital

I/AMA—**Management of The Pregnant Diabetic** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

March 13, 1970; Williamsport Hospital

I/AMA—**The Physicians Role in Sex Education** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Altoona Hospital

I/AMA—**Agressive Management of Patients with Stroke** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

April 2, 1970; Altoona Hospital

I/AMA—**Emotional Problems at Adolescence** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

GENERAL

October 30-31, 1969; Philadelphia

C—**Blood cells as a Tissue** (Sixth International Tissue Research Conference); at Lankenau Hosp. Contact William L. Holmes, Ph.D., Div. of Research, Lankenau, Lancaster & City Line Aves., Philadelphia 19151.

MICROBIOLOGY & IMMUNOLOGY

September-December, 1969, (3rd Thurs. ea. mo.); Bethlehem

I—**Immunology;** at St. Luke's Hosp.; by Jefferson; 20 hrs. AAGP credit; $20 fee (5 seminars), $7 each. Contact Michael L. Sheppeck, M.D., Med. Dir., St. Luke's Hosp., Bethlehem 18015.

OPTHALMOLOGY

July 7-October 24, 1969; Philadelphia

S—**Ophthalmology;** at U. of Pa.; 7 hrs. a day, 88 days; $1,075 fee; 50 max. regis. Contact Paul Nemir, Jr., M.D., Div. of Grad. Med., U. of Pa., Hamilton Walk, Philadelphia 19104.

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each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydroxide (Warner-Chilcott)
200 mg. magnesium hydroxide

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a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patient

Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

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Gelusil® Tablets

the universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

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Morris Plains, New Jersey

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obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Martin B. Finneran,** Carbondale; University of Pennsylvania School of Medicine, 1917; age 76; died April 9, 1969. Dr. Finneran had been chief of staff at Carbondale General Hospital, and was a fifty-year member of the Lackawanna Medical Society. In 1956 he was honored by the Pennsylvania Medical Society when he was named "General Practitioner of the Year." He is survived by his wife, two sons, one of whom is John J. Finneran, M.D., Milwaukee, Wisc., and a sister.

○ **Harry P. Hoffman,** Bloomsburg; Hahnemann Medical College, 1943; age 51; died March 20, 1969. He served in the Navy in World War II. He is survived by two sons, a daughter, his mother and two sisters.

○ **Samual Simkins,** Philadelphia; University of Pennsylvania School of Medicine, 1931; age 61; died March 31, 1969. He was assistant professor of medicine at Hahnemann Medical College, and was an associate in medicine at Albert Einstein Medical Center. He is survived by his wife, two sons, a daughter, two brothers and a sister.

○ **G. Gordon Snyder,** Bryn Mawr; Temple University School of Medicine, 1934; died March 21, 1969. He was chief of service in Otolaryngology at Bryn Mawr Hospital, and assistant professor of otolaryngology at Temple University Medical Center. Surviving are his wife, a daughter and a son G. Gordon Snyder, III, M.D.

○ **Eugene J. Truschel,** Pittsburgh; University of Pittsburgh School of Medicine, 1917; age 77; died April 4, 1969. He is survived by his wife a son and a daughter.

○ **William R. Vernon,** Perryopolis; Temple University School of Medicine, 1926; age 74; died March 27, 1969. He served in the Infantry during World War I, and was a member of the staff of Charleroi-Monessen Hospital for thirty-five years. Surviving are his wife, a son, a brother, and five sisters.

○ **Leland F. Way,** St. Petersburg, Fla.; Emory University School of Medicine; age 76; died April 4, 1969. In 1966 he received the PMA award for fifty years of service to medicine. Survivors include his wife, a daughter, a son and a sister.

○ **Chester A. Billetdoux,** Philadelphia; Jefferson Medical College, 1910; age 82; died December 26, 1968. No other information is available.

Philip J. Callaghan, Williamsport; Jefferson Medical College, 1942; age 53; died April 2, 1969. He was a member of the American College of Chest Physcians and had received the Purple Heart during his service as battalion combat surgeon during World War II. He was chief of medicine at Altoona Veterans Hospital at the time of his death. Survivors include his wife, two brothers and two sisters.

○ **John R. Gray,** Wexford; University of Pittsburgh School of Medicine, 1934; age 64; died April 5, 1969. He was a member of the American College of Surgeons. Survivors include his wife, a son, a daughter, and a sister.

○ **Walter J. Lace,** Vandergrift; University of Pittsburgh; age 81; died April 4, 1969. He was school physician and surgeon for the Vandergrift plant of United States Steel Corporation. He had practiced in the community for 55 years, and had served in the U. S. Army Medical Corps during World War I. Surviving are his wife, two sons, two brothers and a sister.

○ **Benjamin Singer,** Philadelphia; University of Pennsylvania School of Medicine, 1900; age 91; died April 9, 1969. He is survived by his wife, three sons and a daughter.

○ **Paul B. Stewart,** Naples, Fla.; University of Buffalo School of Medicine, 1911; age 82; died April 12, 1969. He is survived by his wife and a son.

○ **Charles S. Schafer,** Philadelphia; University of Pennsylvania School of Medicine, 1914; age 77; died May 9, 1969. He was a World War I veteran and a recipient of the PMS award for fifty years of service to medicine. He is survived by his wife and two sons, Rabbi Stephen Schafer, Allentown, and Richard L. Schafer, M.D., Toledo, O.

○ **Michael Susman,** Philadelphia; Jefferson Medical College, 1908; age 83; died May 19, 1969. He practiced medicine for over fifty years before his retirement in 1966. His wife survives.

○ **William A. Rote,** Pittsburgh; University of Pittsburgh Medical School, 1926; age 68; died April 26, 1969. He was a member of the American College of Surgeons and a veteran of World War II. He is survived by his wife and three daughters.

○ **Frank G. Runyeon,** Reading; University of Pennsylvania School of Medicine, 1903; age 87; died May 17, 1969. No survivors are listed.

David R. Faringer, Philadelphia; University of Pennsylvania School of Medicine, 1909; age 85; died May 11, 1969. He is survived by his wife, a daughter, and a son, David R. Faringer, Jr., M.D.

Clifford B. Jones, Philadelphia; University of Pennsylvania School of Medicine, 1908; age 82; died May 1, 1969. He is survived by his wife, three sons and a daughter.

Charles F. Kissinger, East Palestine, O., University of Buffalo School of Medicine, 1931; age 68; died April 25, 1969. He formerly practiced in Pennsylvania in Enon Valley and Zelionople. His wife survives.

Warren T. O'Hara, New Kensington; Jefferson Medical College, 1913; age 81, died May 8, 1969. Survivors include his wife, three sons, a stepdaughter, and a brother.

Edward R. Proctor, Pomona, Calif.; Columbia University Medical College, 1922, age 72; died May 1, 1969. He formerly practiced surgery in Lancaster before moving to California in 1943. He is survived by his wife, Louisa Keasbey, M.D., and two daughters.

John C. Sherger, Duncannon; Jefferson Medical College, 1935; age 60; died May 6, 1969. He was a practicing physician in the Harrisburg area for more than thirty years. He is survived by his wife and daughter.

Edward V. Stanton, Utica, N.Y., Jefferson Medical College, 1937; age 57; died May 3, 1969. He had been on the Utica State Hospital staff for five years. He is survived by his wife, two daughters, two sons, three sisters and a brother.

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FILMS: Twenty-minute color film, *The Technique of Intra-Articular and Peri-Articular Injection,* available without charge to members of the medical and related professions from The Upjohn Professional Film Library, Kalamazoo, Mich. . . *The Psychotic Child,* a documentary film produced at the Eastern Pennsylvania Psychiatric Institute, available for showings to professional audiences from the Pennsylvania Department of Public Welfare Film Library, Harrisburg, Pa.

BOOKLETS: *Safety Belts Save Lives,* 15 cents from Order Handling, American Medical Association, 535 N. Dearborn St., Chicago, Ill., 60610.

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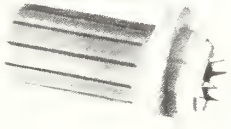

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TEMPLE UNIVERSITY HEALTH SCIENCE CENTER presents the 13th Annual Postgraduate Course, Recent Advances in Medicine, on 8 consecutive Wednesdays from October 15th to December 3rd, 1969, from 11:00 a.m. to 4:00 p.m.

Aims of Course: Problems in Clinical Practice

Methods: Grand Rounds, Clinics, Case Discussions, Office Procedures, Lectures and Panel Discussions, all with audience participation.

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Dr. David P. Lauler, Harvard Medical School, Peter Bent Brigham Hospital.

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Albert J. Finestone M.D.
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The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected... or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0 5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

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How Supplied: Tablets, bottles of 50.

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meetings

JULY

Pennsylvania Board for improvement pf Health Care in Nursing Homes and Related Facilities, 10:30 a.m. Wednesday, July 16, PMS Headquarters, Lemoyne.

American Medical Association's 118th Annual Convention, July 13-17, 1969, New York Coliseum and New York Hilton for Scientific Sessions; Americana Hotel for House of Delegates.

PMS Committee on Objectives, 10 a.m., Wednesday, July 30, PMS Headquarters, Lemoyne.

AUGUST

PMS Board Meeting, 2 p.m., Wednesday, August 13, PMS Headquarters, Lemoyne.

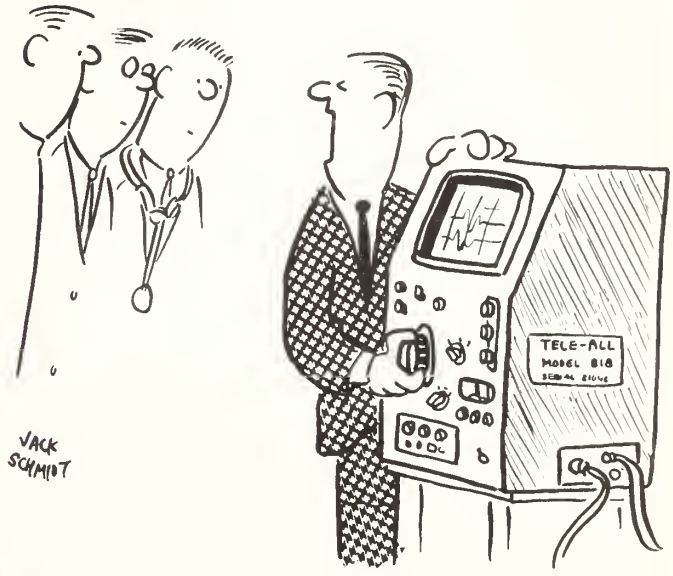
Clean Streams Symposium, Williamsport Regional Office, Pennsylvania Department of Health, 9 a.m., Wednesday, August 20, Lycoming Hotel, Williamsport, Pa.

SEPTEMBER

PMS Scientific Sessions, September 15-18, Host Farm Motel, Lancaster, Pa.

Twenty-ninth Annual Congress on Occupational Health September 15-16, Stouffer's Riverfront Inn, St. Louis, Mo.,

Pennsylvania Chapter of the American Acadamy of Pediatrics, September 20-22, Bedford Springs Hotel, Bedford, Pa.



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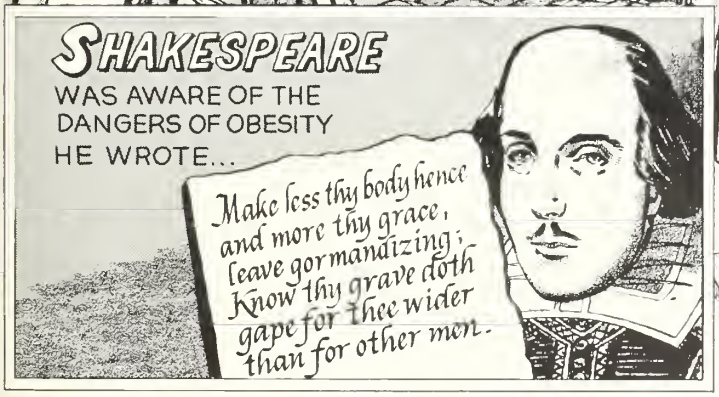

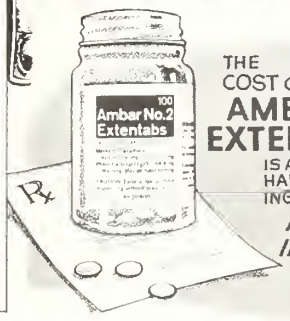

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BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Dr. Pepys Writes Again

We physicians owe a lot to Morris Fishbein, M.D., and now we have incurred an additional debt. His just-published autobiography* gives us a great many new benefits. They would doubtless be placed in different ranks by different readers, but the book has a great deal of value for every reader and, particularly, for the physician interested in medical and voluntary health organizations.

Dr. Fishbein is a professional writer and the fact is obvious at once and on every page. This is not the usual writing of the octogenerian physician who decides to "do" his memoirs and become a temporary litterateur. Dr. Fishbein has made a permanent and large addition to the literature of autobiography.

The book would have great value if only as a record written by a leading actor of the events of the American Medical Association since 1913, the year of Dr. Fishbein's first efforts. He was not merely *there* but he was there with some special kind of vitality which makes his preseence count for more than that of many other persons. In fact, *vitality* may be the keyword of the book; but many other keywords come to mind—humanity, intelligence, self-confidence and a number of others. Whatever came along found our protagonist ready to take part in his own special, personal way. This autobiography is, therefore, an essential part of the record of the modern development of our Association and can give new insights to anyone interested in medical organizations. For the man who has seen more than a decade of organized medicine the book will have a special fascination and the similarity to the writings of Samuel Pepys will be apparent.

So first of all Dr. Fishbein's book is *literature*, maybe not belles-lettres, but literature. Morris knew he had a special relation and resemblance to Samuel Pepys and when he began to write about his own activities he wrote under the nom-de-plume of Doctor Pepys. Like Samuel, Morris is interested in everybody and everything and people receive notice on the same page as world-shaking events. Most of all Morris is interested in Morris as Samuel was interested in Samuel. And this gives a rare flavor to the writing and makes the book a delightful one. I take pleasure in recommending it!

CBL

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* MORRIS FISHBEIN, M.D. An Autobiography. Doubleday and Company, Inc., Garden City, New York. 1969.

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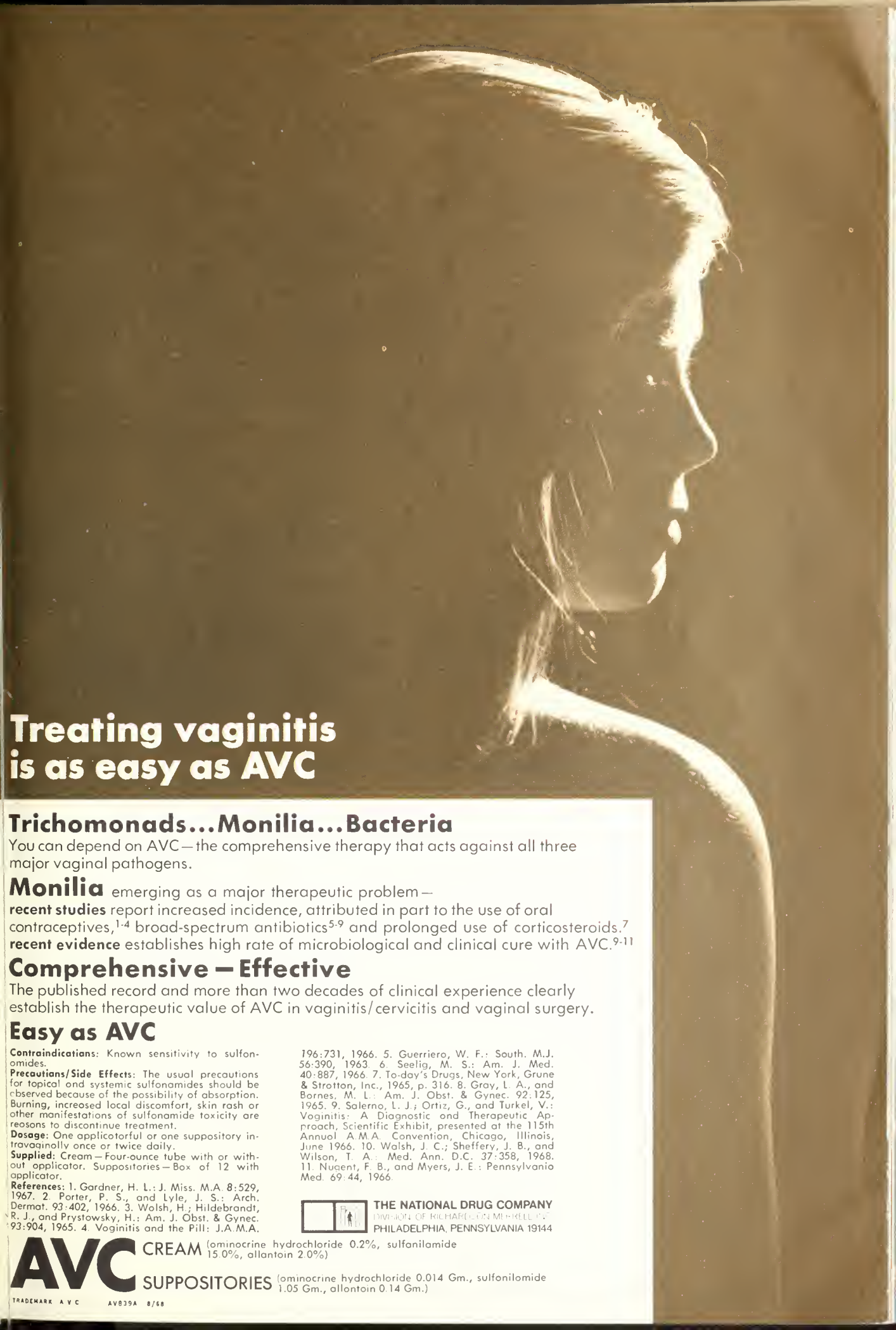

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References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Wolsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Bornes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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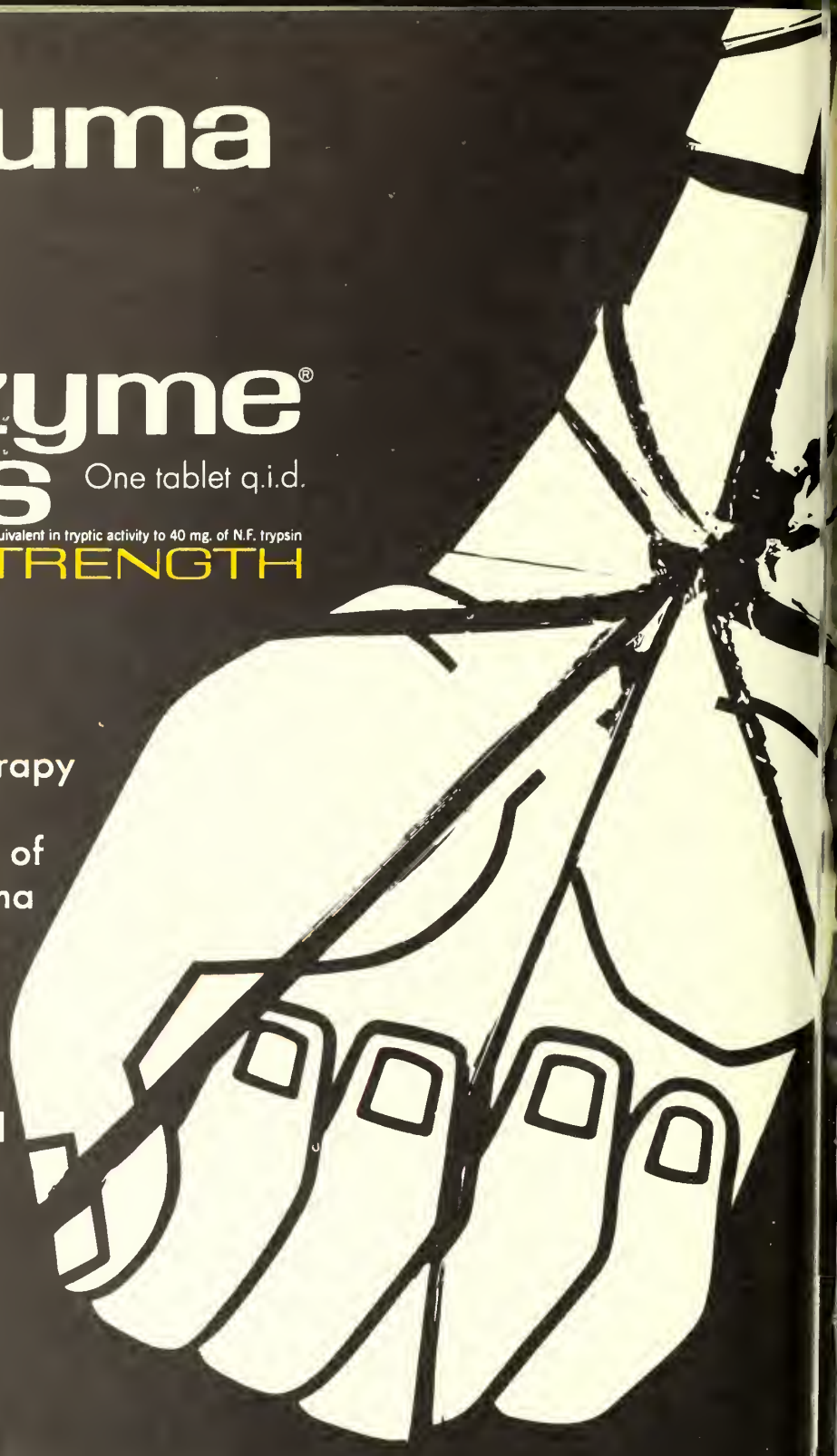

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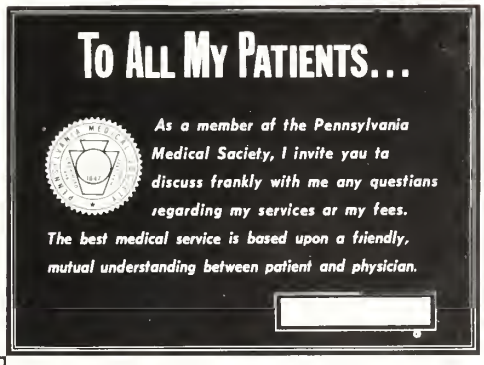

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dasage (initially 10 mg or less per day) ta preclude ataxio or aversedatian, increasing gradually as needed and talerated. Nat recammended in children under six. Though generally nat recammended, if cambinatian therapy with ather psychatrapics seems indicated, carefully cansider individual pharmacalagic effects, particularly in use af potentiating drugs such as MAO inhibitars and phenathiazines. Observe usual precautians in presence af impaired renal ar hepatic function. Paradoxical reactions (e.g., excitement, stimulatian and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautians in treatment af anxiety states with evidence af impending depressian; suicidal tendencies may be present and pratective measures necessary. Variable effects an blaad coagulation have been reported very rarely in patients receiving the drug and oral anticaagulants; causol relatianship has nat been established clinically.
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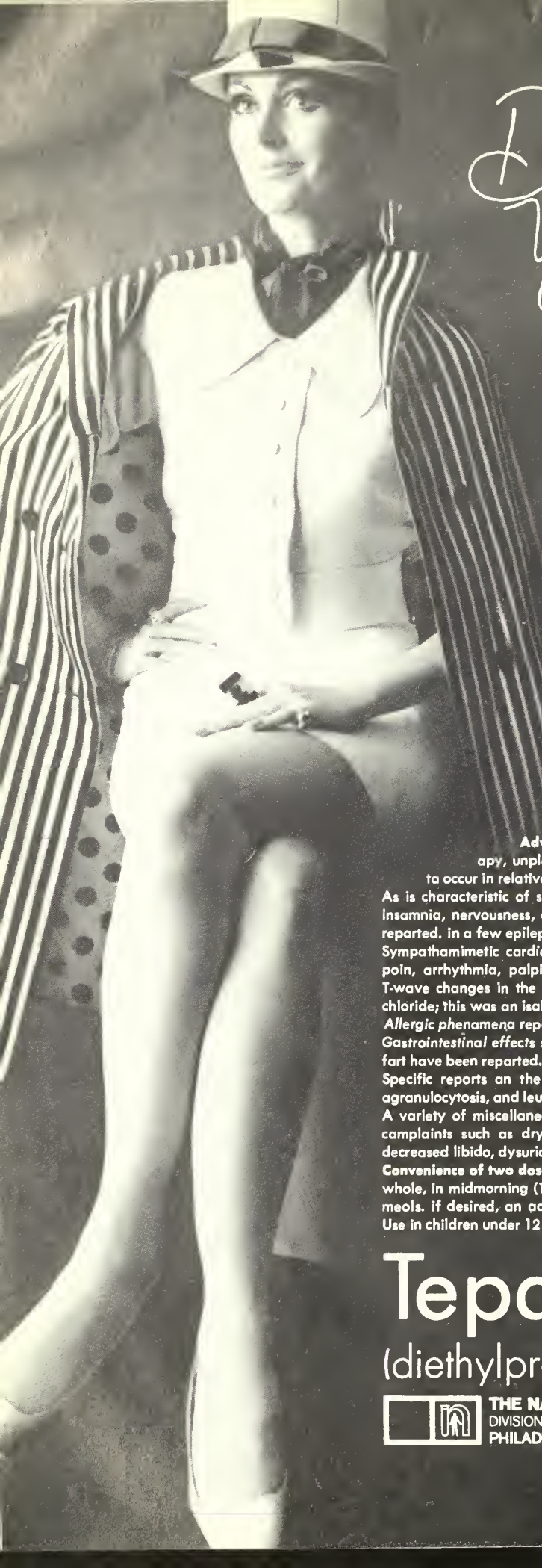

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As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported.

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Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema.

Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported.

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A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

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THE PENNSYLVANIA MEDICINE / medigram

AUGUST, 1969

PENNSYLVANIA PHYSICIANS ELECTED TO HIGH POSTS IN AMA; PMS EXECUTIVE DIRECTOR HONORED; DISTAFFER RE-ELECTED AS AUXILIARY TREASURER

Two Pennsylvania physicians were named among the three highest elected officers at the American Medical Association Convention in New York City last month. Russell B. Roth, M.D., of Erie, was elected Speaker of the AMA House of Delegates, moving up from the Vice-Speaker's post which he has held for three years. M. Louise C. Gloeckner, M.D., of Conshohocken, was named AMA Vice-President, to serve with Gerald D. Dorman, M.D., of New York City, who was installed as President. Doctors Roth and Gloeckner were unopposed in their nominations and were elected by acclamation. Dr. Roth practices urology and was a partner of the late Elmer Hess, M.D., who was president of the AMA in 1955-56. Dr. Gloeckner, a general practitioner, was a member of the AMA House of Delegates for 19 years, spending nine years as alternate delegate and ten years as a delegate before she decided last year not to seek reelection. Upon her election to the vice presidency, she was presented a bouquet of red roses by Samuel Cohen, M.D., chairman, Montgomery County Medical Society board of trustees amidst a standing ovation. In addition, one of the five AMA council posts filled by the House at this session went to a Pennsylvanian, William A. Sodeman, M.D., of Rosemont. Dr. Sodeman was reelected to a term on the important AMA Council on Medical Education.

Mr. Perry

Mrs. Beckley

The AMA House of Delegates paid tribute to Lester H. Perry, retiring executive director of the Pennsylvania Medical Society. In a brief statement before the House, Thomas W. McCreary, Sr., M.D., chairman of the Pennsylvania Delegation to the AMA, stated that: "For all of these 35 years, he (Mr. Perry) has focused on the problems of medicine an unusually clear and thorough reasoning so essential as the precursor of definitive action. Then, he has brought to the implementation of actions, a husbandry rarely if ever equaled." The AMA House recognized "with pride" his contributions and confessed its sense of loss that his direct service is about to end and wished him long and happy years of well-earned retirement. Mr. Perry will retire as PMS Executive Director in October of this year.

Mrs. Robert Beckley, of Lock Haven, was elected to a second term as Treasurer of the Woman's Auxiliary of the AMA.

HOSPITAL ASSOCIATION MEETS WITH GOVERNOR

Board members of the Hospital Association of Pennsylvania met recently with Governor Raymond P. Shafer to discuss the impact of the proposal to cutback income eligibility for state medical aid from $4,000 annually for a family of four to $3,400 annually. Sister M. Ferdinand Clark, HAP president said the cutback will cost hospitals $28 million. Budget shaving for the state by such a move amounts to $15.4 million, while $12.6 million comes from federal matching funds. The HAP president declined to call this a saving for the Commonwealth, and called it simply a transfer of a small charge for the state into a "crushing burden" on the hospitals. The HAP Board of Directors spoke for 280 hospitals in Pennsylvania. The cutback would remove 300,000 Pennsylvanians from the rolls of those eligible for medical assistance, and would mean that a family of four living on $65 per week would be forced to pay all medical costs for the family. Walter Shakespeare, administrator of Harrisburg Hospital said, "Unless the General Assembly moves to provide the $109.3 million requested by the governor for the state's medical assistance program for the 1969-70 fiscal year, Harrisburg Hospital stands to lose at least $412,672." He voiced the feelings of hospital administrators throughout the state, many of which are beginning to take steps to cut back services. Passage of a revised total appropriation of $338 million for state welfare programs, which includes the figure for medical assistance, would permit withdrawal of the cutback in income eligibility for medical assistance.

DEPARTMENT OF HEALTH TO STUDY INJURIES CAUSED BY CONSUMER PRODUCTS

The Pennsylvania Department of Health has received a first-year $69,317 grant from the Food and Drug Administration of the U. S. Public Health Service for a three-year study of injuries involving the use of consumer products. The study will be directed by the Division of Research and Biostatistics in the metropolitan areas of Harrisburg and York, and will ascertain the relationships of consumer products to accidental injuries. Institutions collaborating in the project are: Harrisburg Hospital; Harrisburg Polyclinic Hospital; York Hospital and Holy Spirit Hospital, Camp Hill.

Special in this Issue:

PMS 1969 SCIENTIFIC SESSION PROGRAM

A complete program listing for the PMS 1969 Scientific Session may be found in this issue of Pennsylvania Medicine, beginning on Page 53. The program includes all of the PMS seminars, specialty group programs and meetings, meetings of nurses and allied professions and other important events.

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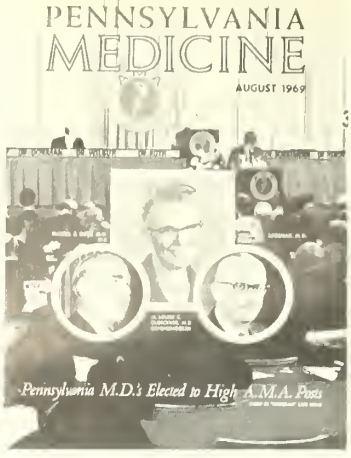

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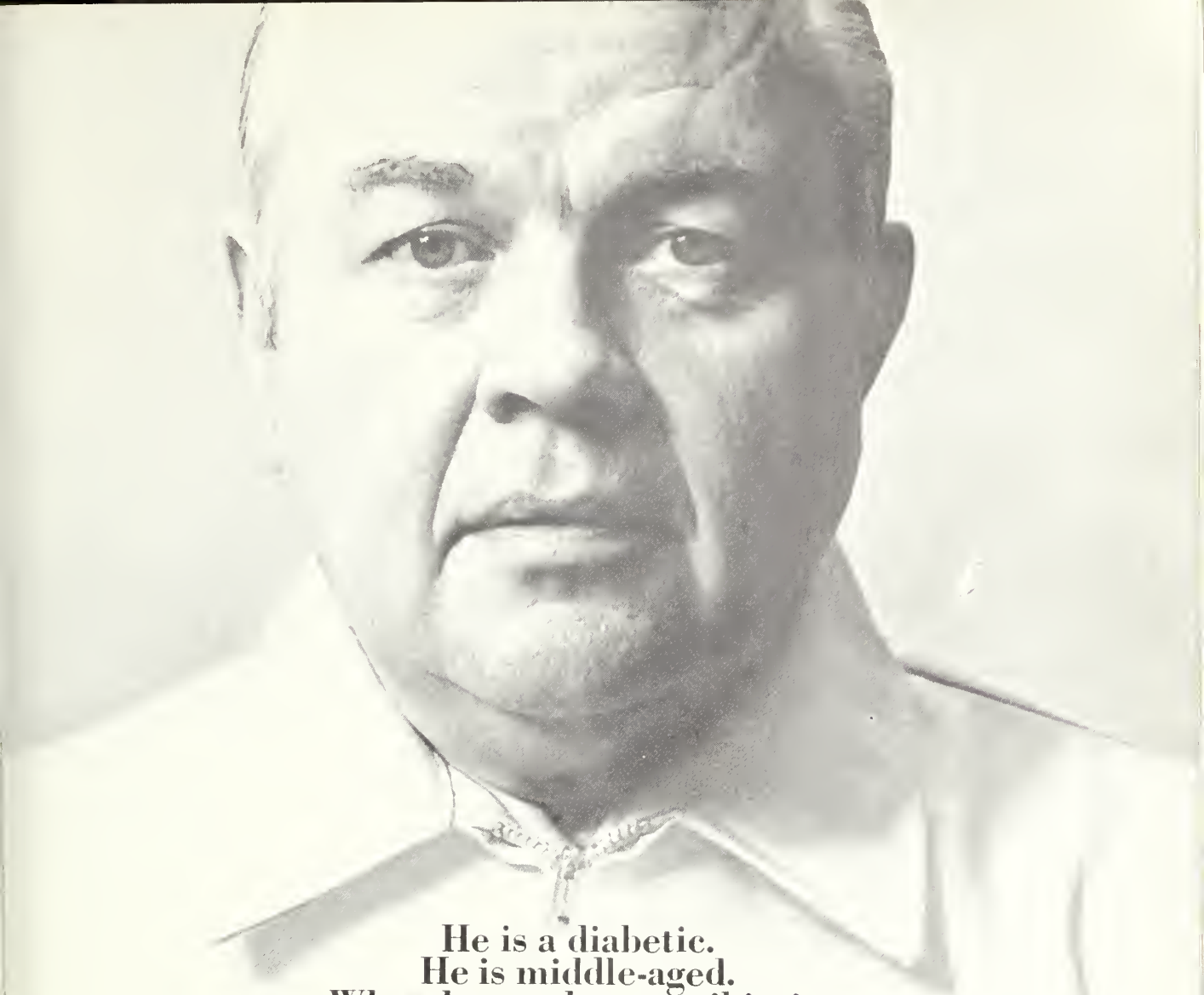

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ntraindication: History of hypersensitivity to demethylchlortetracyne or nystatin.

arning: In renal impairment, usual doses may lead to excessive accumtion and liver toxicity. Under such conditions, lower than usual doses e indicated, and, if therapy is prolonged, serum level determinations y be advisable. A photodynamic reaction to natural or artificial sunht has been observed. Small amounts of drug and short exposure may oduce an exaggerated sunburn reaction which may range from erytma to severe skin manifestations. In a smaller proportion, photoergic reactions have been reported. Patients should avoid direct posure to sunlight and discontinue drug at the first evidence of skin comfort. Necessary subsequent courses of treatment with tetracynes should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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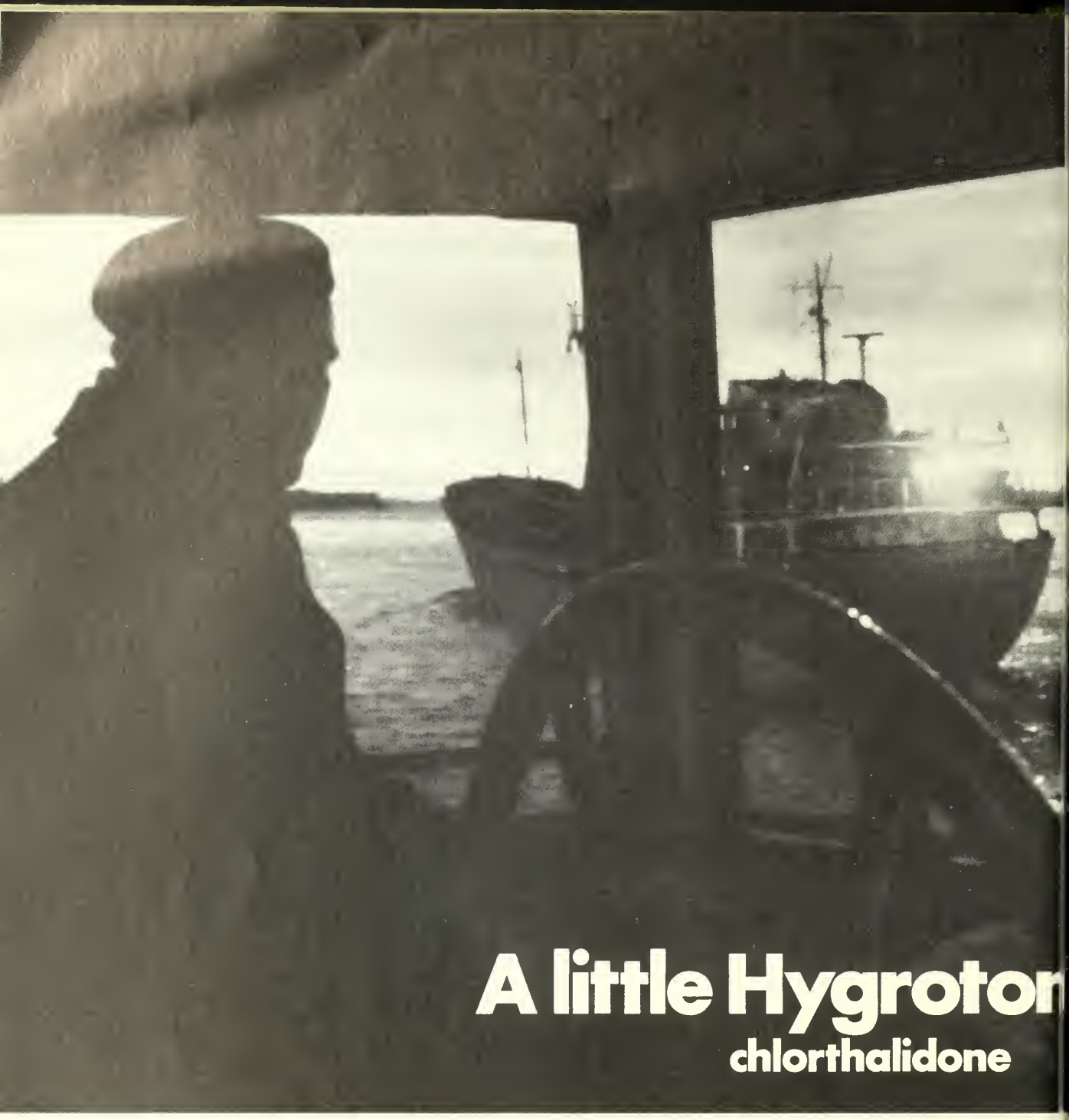

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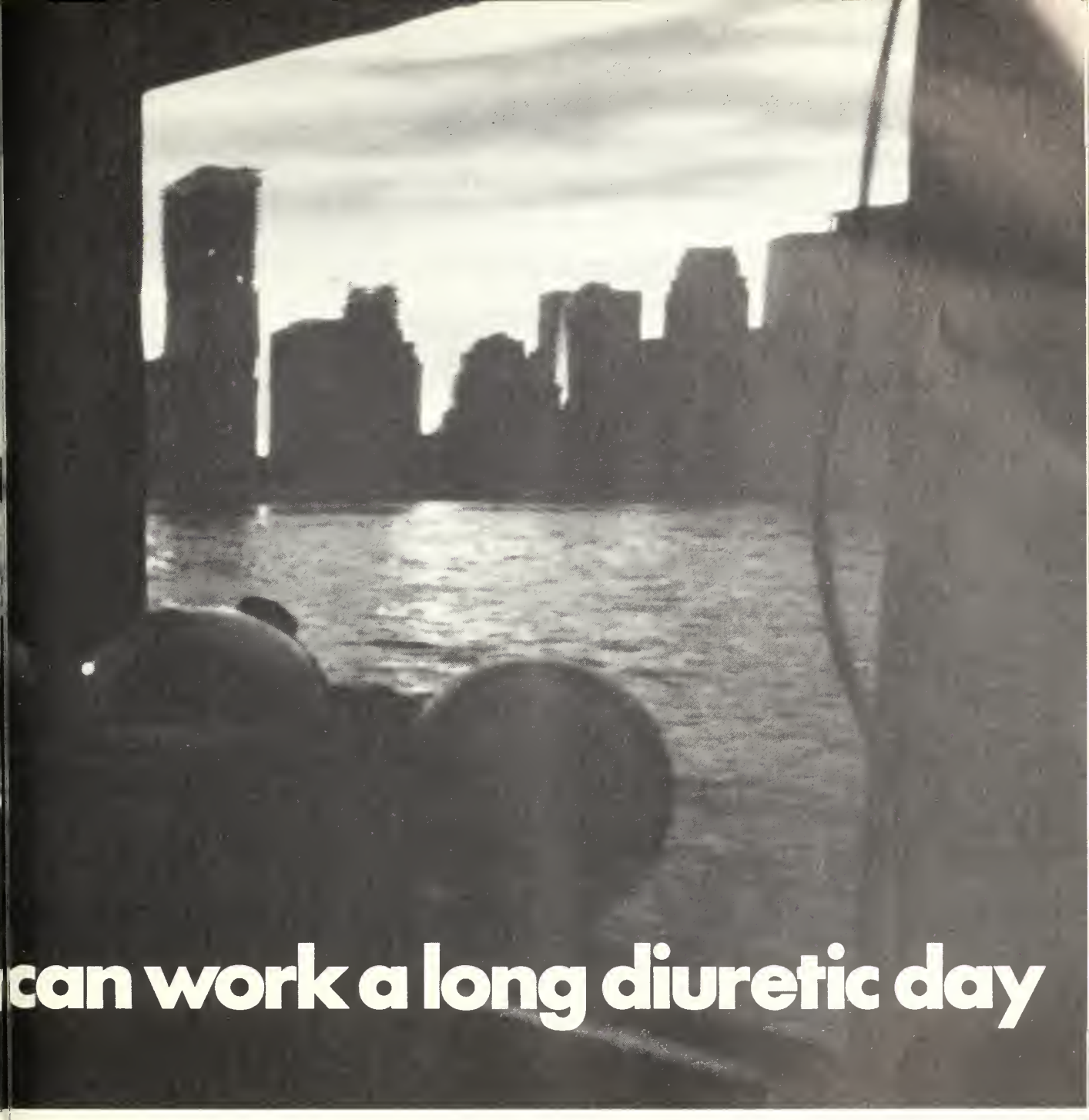

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chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

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newsfronts

"An Evening With Les Perry"

PMS Executive Secretary Lester H. Perry *was feted by the Dauphin County Medical Society at a recent meeting preceded by a reception and dinner. Shown here (left to right) are John H. Harris, Sr., M.D., former PMS and DCMS president, William A. Sullivan, M.D., program chairman for the Dauphin County Medical Society, Mr. Perry, and Allen W. Cowley, M.D., past president of the DCMS and PMS Secretary.*

Dauphin County Honors PMS Executive Director

"An Evening with Les Perry" was the theme of a recent meeting of the Dauphin County Medical Society, which honored the PMS Executive Director for thirty-five years of service to the Society. Mr. Perry will retire in October.

During the evening past presidents, officers, committee members and PMS delegates of the Dauphin County Medical Society welcomed Mr. Perry to a reception and dinner arranged especially in his honor as an expression of the Society's gratitude for his service to organized medicine. Following the dinner, which was held in the Academy of Medicine Building, Harrisburg, R. Edward Steele, M.D., president of the Dauphin County Medical Society, presented an engraved plaque to Mr. Perry "in recognition of and appreciation for thirty-five years of loyal and dedicated service to the medical profession of Pennsylvania."

In presenting the award, Dr. Steele said, "Les has been a familiar figure to all of us in Dauphin County for many years. He does us honor by allowing us to honor him this evening. We congratulate him for his many accomplishments for organized medicine and extend best wishes to him for a happy retirement."

Mr. Perry, the first layman to become executive director of the Pennsylvania Medical Society in its more than 100-year history, will retire at Annual Session from his post. The Board of Trustees has named John F. Rineman as Mr. Perry's successor. After accepting the award and thanking the members for the honor, Mr. Perry spoke on the subject, "The Perennial Challenges of Medicine." (Editor's Note: Text of the speech will appear in a subsequent issue of PENNSYLVANIA MEDICINE.)

Cystinosis Patients Sought For Study

The cooperation of physicians is requested in the referral of patients with cystinosis to participate in studies being conducted by the National Institute of Arthritis and Metabolic Diseases at the Clinical Center, National Institutes of Health in Bethesda, Maryland.

Of particular interest are pregnant women who are mothers of cystinotic patients. There is reason to believe that in-utero diagnosis of cystinosis can be achieved. There is special interest in studying women, as early in pregnancy as possible, who are at risk for giving birth to a cystinotic child.

Physicians who wish to have their patients considered for these studies may write or telephone: Jarvis E. Seegmiller, M.D. or Joseph D. Schulman, M.D. Clinical Center, Room 8-D-19, National Institutes of Health, Bethesda, Maryland 20014, telephone: (301) 496-4781.

newsfronts

"To Fight Drug Abuse"

Check for $10,000 *to fight drug abuse is presented to Wilson C. Everhart, M.D., representing the PMS Council on Public Service, by officials of the Pennsylvania Federation of Women's Clubs. The officials are, from left, Mrs. John M. Spatz, of Pittsburgh, the president; Mrs. Rex T. Wrye, of Camp Hill, project chairman; and Mrs. Henry B. Brillinger, II, of Mechanicsburg, project vice-chairman. The drug abuse education project is a joint effort of the federation and PMS and will get under way soon with a series of sound, color film public service announcements on television stations.*

U.S. Agency Requests

AMA Viet Nam M.D. Program Extended

The American Medical Association has been asked by the U. S. Agency for International Development to continue administering the Volunteer Physicians for Viet Nam program for another two years.

To maintain thirty-two physicians in Viet Nam at any one time, however, will require 400 more volunteers between now and June 1971, AMA points out.

It is particularly urgent that more applications from physician volunteers be received for this last half of 1969, program officials say. The greatest need for general practitioners, general surgeons, internists, orthopedic surgeons, ophthalmologists, pediatricians, and preventive medicine specialists.

For further information, physicians may contact Charles H. Moseley, M.D., director, Volunteer Physicians for Viet Nam Program, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. Telephone inquiries can be made to area code 312, 527-1500, extension 422.

A special reception for volunteers was held at the U. S. Department of State to mark the departure of tne 600th physician to go to Viet Nam through this program. Dr. John A. Hannah, former president of Michigan State University who now is Administrator of the Agency for International Development, noted on that occasion: "These physicians volunteer to serve in Viet Nam not because it is where the action is, but because it is where the need is."

PMS Medical Practice Course Slated For Danville This Fall

Interns and residents in the Danville area will have an opportunity this fall to learn about the mysteries of establishing a medical practice.

A six hour course, developed by the Pennsylvania Medical Society's Council on Public Service, will be presented in one-hour weekly sessions at the Geisinger Medical Center on Thursdays at 4:00 p.m., beginning September 11. With the exception of October 9, which is the start of the State Society's Annual Business Session, the programs will run consecutively.

Entitled "You, Medicine and Success," the course is designed to provide much needed information on the socio-economic aspects of medicine to physicians about to enter medical practice. Included are such topics as: the best defense against malpractice suits; procedures for selecting a place to practice and establishing a medical practice; methods to set up an office and manage it properly; consideration of medical practice insurance and personal financial planning; and a philosophical discussion on how to succeed as a physician.

The trial course at Geisinger, along with a similar program planned for a university based hospital, will be carefully evaluated by the Council to determine the feasibility of offering it on a statewide basis. Dates and location for the university hospital program have not been completed.

Environmental Health Consultants Sought

The Council on Education and Science and the Commission on Environmental Health are seeking interested and knowledgeable physicians in the following areas of environmental health: (1) water pollution, (2) air pollution, (3) solid waste removal, (4) noise pollution, and (5) chronic poverty as related to health, to act as consultants on these vital problems to the commission. Anyone interested please write to the Pennsylvania Medical Society, Taylor Bypass and Erford Road, Lemoyne, Pa. 17043, c/o Terry R. Lenker.

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Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles. **A.H.F.S. Category 8:12.16**

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Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.

Contraindications: Evidence of or a history of blood dyscrasia, in patients with active organic disease of the central nervous system, and the first trimester of pregnancy.

Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers; it is not known whether this can be injurious to the newborn.

Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.

Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weak-

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lasting Flagyl eradicates resistant, deep-seated invasions of *Trichomonas vaginalis* and consistently produces cure rates above 90 per cent and often as high as 100 per cent in large series of patients. When the diagnosis is positive, Flagyl is positive.

ness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: In the Female. One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg insert is placed high in the vaginal vault each day for ten days and the *oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment.* Do not use the vaginal inserts as the sole form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets . . . . .250 mg.
Vaginal inserts . . .500 mg.

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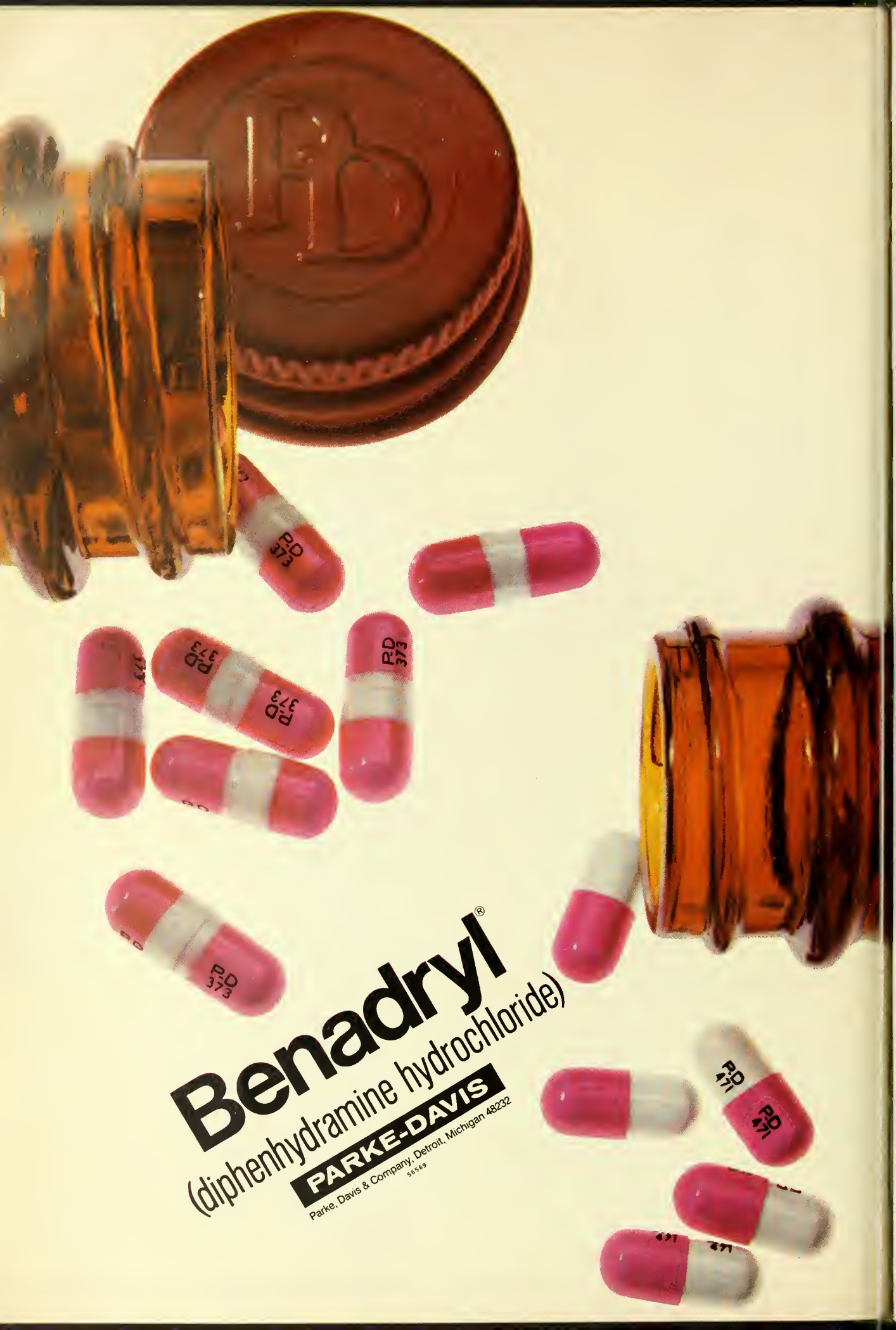
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newsfronts

Blood Donor Age Limit Raised to 66

Americans in good health can be blood donors now until their sixty-sixth birthday instead of the sixtieth or sixty-first as in the past.

A joint announcement of this liberalization of medical standards for blood was made today by the American Association of Blood Banks, Chicago, Ill., and by the American National Red Cross in Washington, D.C. The two organizations together collect and process 90 per cent of the more than 6,500,000 pints of blood used annually for surgery and therapy in the U. S.

"This extension of the eligible age limit for blood donors is in recognition of two facts," explained Dr. Frank Coleman of Tampa, Florida, President of the Association. "First, that the need for blood is constantly increasing at a rate of about 12 per cent annually. Second, thanks to better medical care, better nutrition and other factors, Americans are living longer and also keeping their health and vigor longer than in the past."

Dr. Tibor J. Greenwalt, Medical Director of the American National Red Cross Blood Program, emphasized that any healthy person can give a pint of blood without worry.

He said, "we have many donors who have given eleven, twelve and even thirteen gallons of blood without incident. Most of these are eager and able to continue giving. The change will permit them to do so except in jurisdictions where it is contrary to local regulations."

Donors sixty-six years of age or over, under the new AABB and ARC policies, may continue to give blood if they obtain the written consent of their personal physician on the day of donation.

Donors must be in good health, have normal temperature, pulse and blood pressure, and meet the other requirements for blood donors. Individuals should check with their local community or hospital blood bank or Red Cross blood center relative to their eligibility to give blood.

State laws generally require blood donors to be twenty-one years old or to have parental consent to give between eighteen and twenty-one, but a number of states, including California, Kansas, Washington, New York, Indiana, Oklahoma, Minnesota and Oregon, recently enacted legislation permitting those eighteen to twenty-one to give without parental consent. In some states those of this age who can give blood must be self-supporting and living away from home. Both organizations have blood clearinghouses, permitting blood given locally to be credited to patients in other cities and areas with surplus blood to aid those where it is short. Exchanges between the two clearinghouse systems are made possible under a joint interorganizational agreement signed between the AABB and ARC.

Chairman William B. West, M.D., *right, accepts the second place political leadership award on behalf of PaMPAC from James A. Sammons, M.D., chairman of the AMPAC board of directors.*

PaMPAC Honored For Service

The Pennsylvania Medical Political Action Committee recently received the second place award "in recognition of its outstanding contribution to the political action movement and the political leadership it has demonstrated during the past year.

The award was made at a public affairs workshop conducted by the American Medical Political Action Committee at the Sheraton Park Hotel, Washington, D. C. William B. West, M.D., PaMPAC chairman, received the award from James A. Sammons, M.D., chairman of the Board of Directors of AMPAC. The Indiana Medical Political Action Committee received the first place award.

In accepting the award Dr. West said "We are happy to be in this second place spot for the past several years. PaMPAC is shooting for first place in this category next year."

Participants in the workshop were physicians, government representatives, members of Congress, AMA and AMPAC staff members and representatives of business.

AMA President Dwight L. Wilbur, M.D., and Ernest B. Howard, M.D., executive vice president of AMA, participated in the program which emphasized the theme that the physician's role as a citizen should be one of expression and action in the interest of the betterment of medicine.

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.

newsfronts

M.D.'s Offered Lab Proficiency Test

An opportunity for physicians to evaluate their own laboratory's proficiency and quality control now is being offered in a new office laboratory proficency evaluation program designed by the College of American Pathologists for general practitioners, internists, pediatricians, and others.

Russell J. Eilers, M.D., chairman of the standards committee, said the proficiency evaluation program is directed to the physician who does limited laboratory work for his patients and to small group practices which have laboratories providing limited laboratory services.

Each mailing will contain: (1) A whole blood specimen for a hemoglobin determination, (2) a lyophilized chemistry specimen for a glucose and BUN determination, and (3) a lyophilized urine specimen for specific gravity, protein, reducing substances, bile, and hemoglobin.

Cost of the 1969 testing packet is $45 and includes two mailings of specimens—one in September and the other in November.

Doctor Eilers explained that the office laboratory program will endeavor to insure high quality laboratory services to patients through interlaboratory evaluation, and "participation will demonstrate a physician's desire for quality laboratory work and the highest standards of patient care.

"It also will serve as an external quality control program," he said, "and assist the laboratory in evaluating currently used methodology and procedures. It will indicate outdated methodology and pinpoint the need for change through a list of corrective steps coded in the evaluation report."

Further information on the office laboratory proficiency evaluation program may be obtained from CAP, 230 N. Michigan Ave., Chicago, Ill. 60601.

Police, Fire Surgeons Plan Association

The cooperation of state and county medical societies has been asked to help form a national society of police and fire surgeons by an ad hoc committee established for that purpose.

The ten-man ad hoc committee has as its chairman Howard Schneider, M.D., police surgeon in Westchester County, New York. Dr. Schneider can provide additional information to interested surgeons who will write to him in care of the National Association of Police and Fire Surgeons, 75 Lee Ave., Yonkers, N. Y. 10705.

Status Report

Courts Uphold FCC "Fairness Doctrine" on Cigarettes

As the battle between the tobacco lobby and the anti-smoking forces rages back and forth on Capitol Hill, it may be helpful for the physician to have some background information on the controversy as it effects advertising of cigarettes on radio and television.

Although thousands of letters have been written to congressmen, senators, the Federal Trade Commission and the Federal Communications Commission objecting to cigarette advertising on radio and TV, it was the single complaint of a young New York attorney that finally precipitated action. The man was John Banzhaf and his letter of complaint to the FCC was different from all the others in one important aspect. Although objecting to cigarette commercials on radio and TV, he first called attention to a rule of long standing in broadcasting known as the "Fairness Doctrine." Stated quite simply, the "Fairness Doctrine" says that a broadcaster has an obligation to treat "controversial issues of public importance" fairly, allowing responsible persons with different points of view, equal opportunity to speak. According to John Banzhaf, the health issues associated with smoking cigarettes were clearly controversial. The commercials by the tobacco companies were patently one-sided. Under the "Fairness Doctrine," the opponents of cigarette smoking were entitled to equal time to present their views.

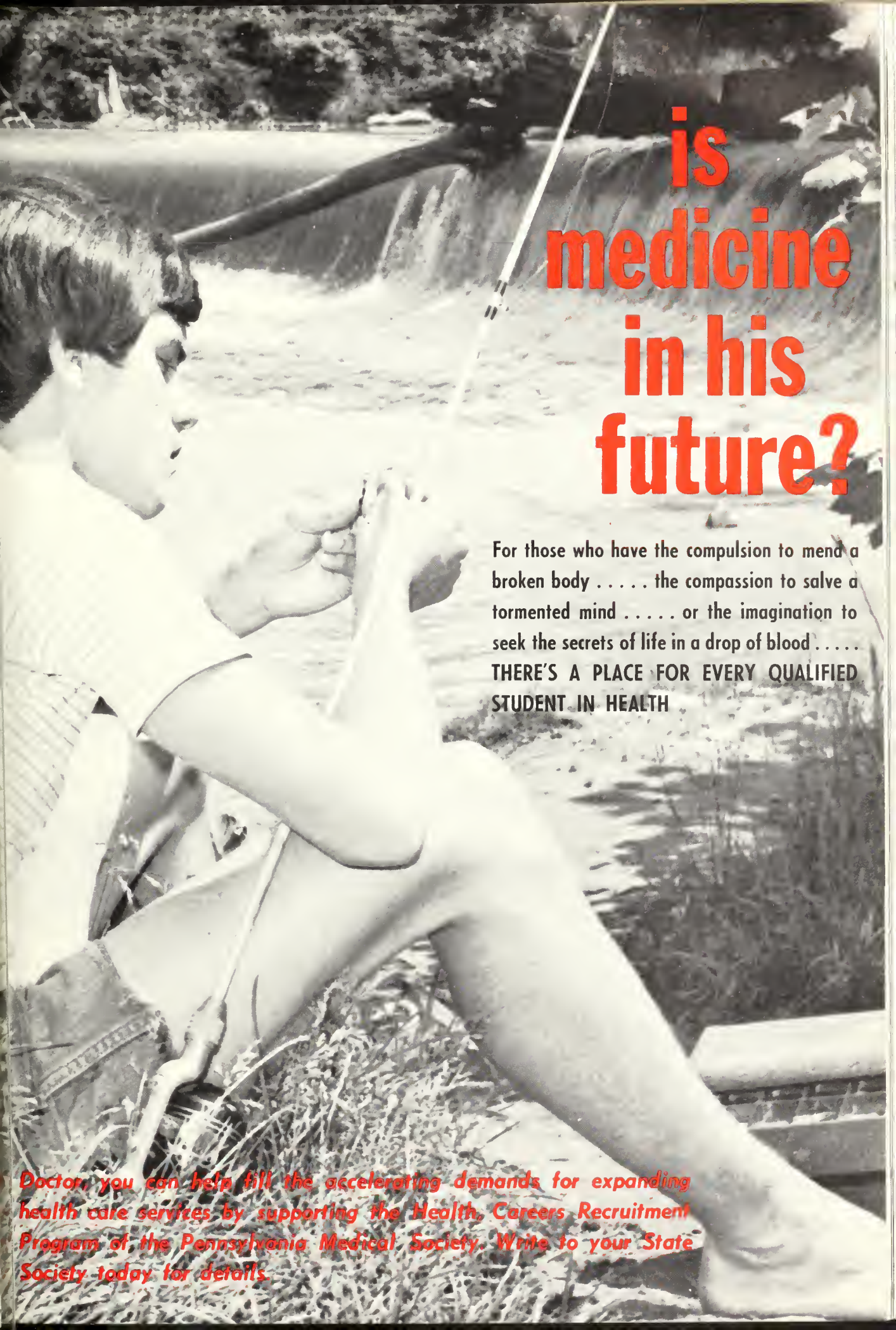
Strict application of the rule also requires that the broadcaster offer air time of equal quality (for example, prime time) for the rebuttal, as was used for the advertisement.

It has been the enforcement of this principle, since upheld in court, that has resulted in the increasing number of anti-smoking spots, seen on prime time television.

As long as the "Fairness Doctrine" is part of the FCC set of guiding regulations, it is logical to assume that other citizens could use the same device to bring pressure on a particular station. Should you be so disposed, you must log the number and length of cigarette and anti-smoking commercials on a particular station, say over a week. If you fail to find a balance of anti-smoking spots, you too would be justified in calling this to the attention of both the station and the FCC.

Needless to say, persons who do this sort of thing, are not favorites of broadcasters, particularly since stations are not paid to carry the anti-smoking spots.

So that this article may not violate its own code of fairness, it should be pointed out that the year since the Democratic Convention in Chicago has not been an easy one for broadcasters. There are many in the Democratic Party who feel that the TV coverage of the convention lost the election for Hubert Humphrey. And in those months since, legislators have paid particular attention to broadcasters. At the same time, reform groups, such as the anti-smokers, and others, have attempted to wrest licenses away from broadcasters of long standing by charging that they have not operated in the public interest. There have been hints from the Justice Department that publishers who own or attempt to buy broadcasting stations in their markets are unjustly monopolizing control of communications. All in all it has been an ulcerous year for broadcasters, as many of you probably know, having seen them as patients.



is medicine in his future?

For those who have the compulsion to mend a broken body . . . . . the compassion to salve a tormented mind . . . . . or the imagination to seek the secrets of life in a drop of blood . . . . . THERE'S A PLACE FOR EVERY QUALIFIED STUDENT IN HEALTH

Doctor, you can help fill the accelerating demands for expanding health care services by supporting the Health Careers Recruitment Program of the Pennsylvania Medical Society. Write to your State Society today for details.

newsfronts

Pathologists, Justice Dept. Reach Compromise

A compromise settlement in a civil antitrust action has been reached between the U. S. Department of Justice and the College of American Pathologists after the federal antitrust division agreed to settle the three-year-old suit.

President Oscar B. Hunter, Jr., M.D., of Washington, D. C., said the college entered into the proposed consent decree "when the Justice Department advised us of a favorable compromise to dispose of the action dating back to 1966." The decree was filed in U. S. District Court in Chicago (Judge James B. Parsons) and is expected to become final in thirty days.

"The settlement in no way," said Dr. Hunter, "constitutes an admission by the college of any of the charges in the complaint or any violation of the law. The College has always contended, and still maintains, that its activities were in the best interests of patients and in full compliance with the antitrust laws.

"The settlement simply represents a compromise, and thus disposes of a matter which would have diverted substantial energies of the college and its members from their primary duties of contributing significantly to the care of sick patients and to the prevention of illness and disability.

"Furthermore, it obviates the necessity of spending a great deal of time and money by both sides on this case."

The 1966 suit had charged the college with alleged price-fixing and boycott agreements to keep non-members out of the medical laboratory business.

Under the decree the college will continue to set standards of operation of clinical laboratories and to inspect and accredit them in its ongoing effort to assure patients and their physicians of the highest quality service.

The college also will continue to police its own ranks, imposing sanctions on a member if he has been found guilty of professional misconduct or deficient in moral character or professional competence.

Further, the college will continue to require that its members report results of laboratory tests only to physicians and others permitted by law to receive such results.

And the college's objectives, under the consent decree, will remain unchanged: (1) To foster the highest standards in education, research, and the practice of pathology; (2) to advance the science of pathology and to improve medical laboratory service, and (3) to maintain the dignity, precision, and efficiency of the medical specialty.

The decree seeks to insure that the college does not insist upon or suggest fee schedules; does not restrict or prevent anyone from owning or operating a laboratory or from referring specimens to any laboratory; does not boycott any person associated with any laboratory, or does not impede anyone from accepting advertising or exhibits from any person.

Dr. Hunter emphasized that the college had never engaged in any of these practices alleged by the government in its suit, and the college "is not now, nor has it ever involved itself in any activities unbecoming to a professional organization.

"The college plans not only to continue its wide range of activities in improving and broadening medical care for patients, but also to expand its 'programs of excellence' for raising laboratory standards and services for the benefit of patients and its member-physicians."

The college has a membership of more than 5,000 pathologists, and is headquartered in Chicago.

Temple Forced to Cut Aid to Poor; Others May Follow

Temple University Hospital has announced its decision to close emergency room services on August 1 and to restrict admissions to those able to pay as of July 1, as a result of a meeting and decision made by administrators of six of Philadelphia's hospitals.

In the face of cuts in city appropriations, Medicare funds, and state welfare aid, six of Philadelphia's hospitals declared their intention to recommend closing their emergency rooms August 1. Similar action is expected to be taken soon by other hospitals. In a joint resolution, administrators of the six hospitals, stated further their intention to recommend to the boards of trustees that admissions to the hospitals be limited to those who meet the criteria established by Governor Raymond Shafer. This refers to the state's announcement that to meet the requirements of the governor's proposed budget, the definition of medically indigent, those eligible to receive medical assistance from the state, from a family of four living on $4,000 a year to a family of four living on $3,400 a year.

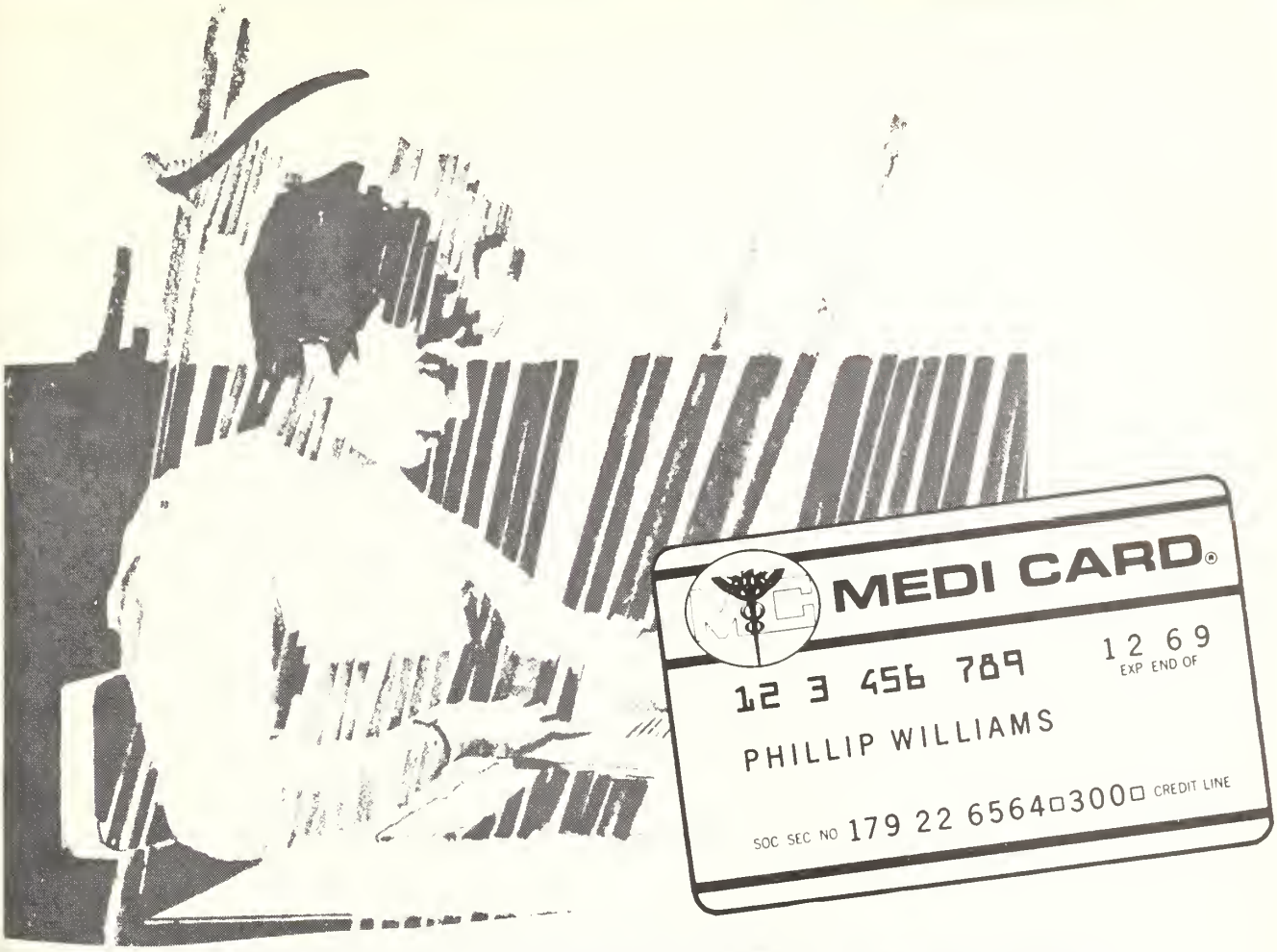
In addition, the administrators will recommend that ambulatory services be limited to those who can pay, are certified on welfare, or are on a continuing care commitment—those receiving care from neighborhood health centers operated by these hospitals, obstetrics cases and children and youth programs.

Those who do not meet the criteria will be referred to Philadelphia General Hospital.

L. E. Burney, M.D., Temple vice president; Charles S. Paxson, Jr., Hahnemann vice-president; George Hay, administrator of Woman's Hospital; Joseph Hughes, St. Joseph's administrator; Milo Anderson, Episcopal administrator; and Curt Pritchard, Wills Eye administrator, jointly made the proposal.

Dr. Burney said, "We regret the necessity of taking such action, but because of the failure of government bodies to fully meet their responsibilities we are placed in an untenable position." Dr. Burney noted that the hospital traditionally has served all who applied to it for help, despite rising costs and deficits.

"We consulted with leaders from our community when the impact of the proposed welfare cutbacks became evident," Dr. Burney said, "and they agreed to help us fight for restoration of the funds which would help us to continue serving the community."



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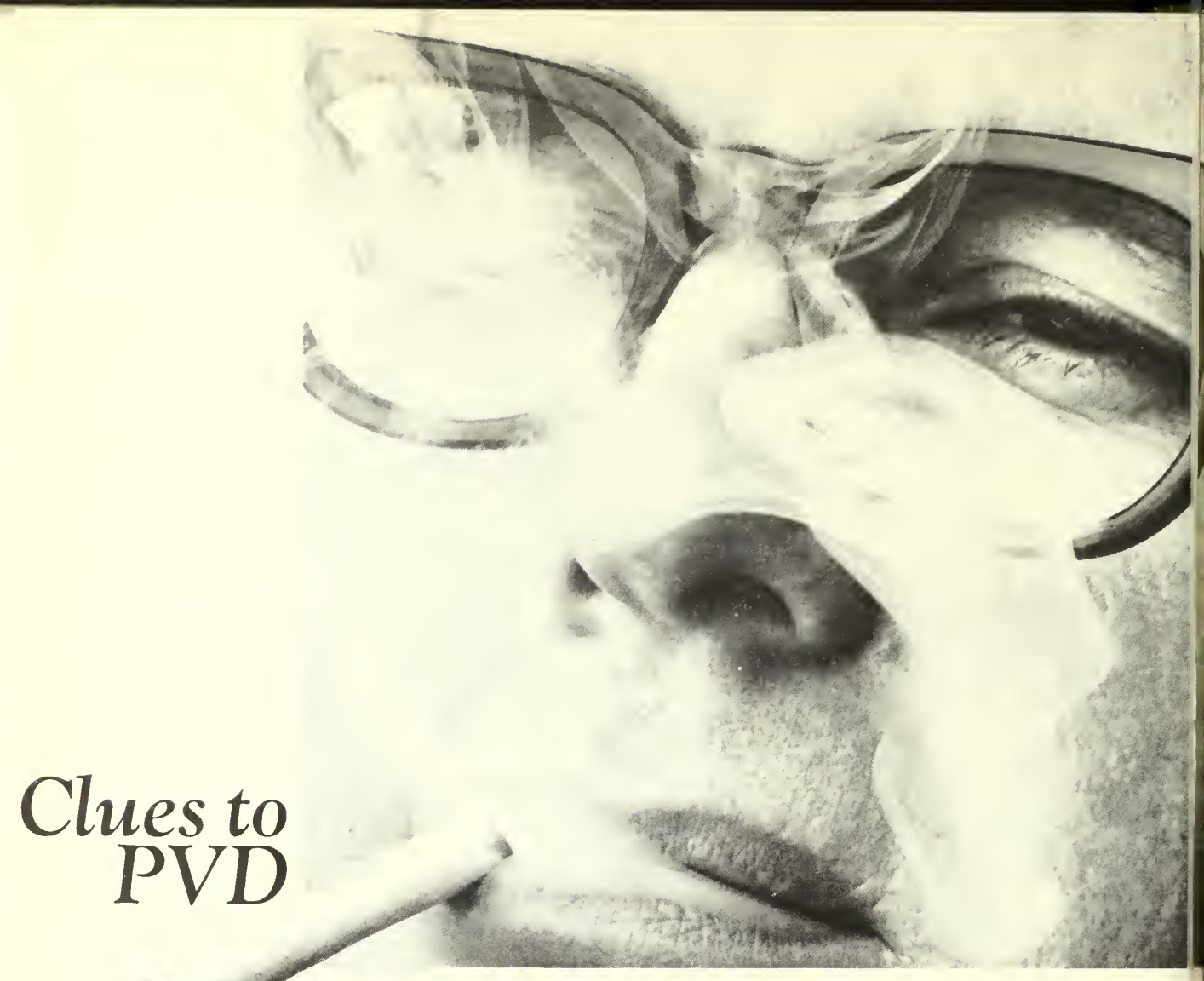

Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50.

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Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol®
Timespan®
(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.

Mild ulcerative colitis may be triggered here...

In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS. Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS. Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CN depressants. As with all CNS-acting drugs, ca tion patients against hazardous occupations r quiring complete mental alertness (*e.g.*, operati machinery, driving). Though physical and ps chological dependence have rarely been report on recommended doses, use caution in a ministering Librium (chlordiazepoxide hydr chloride) to known addiction-prone individua or those who might increase dosage; withdraw symptoms (including convulsions), followi discontinuation of the drug and similar to tho seen with barbiturates, have been reported. U of any drug in pregnancy, lactation, or in wom of childbearing age requires that its potenti benefits be weighed against its possible hazar As with all anticholinergic drugs, an inhibiti effect on lactation may occur.

PRECAUTIONS. In elderly and debilitat limit dosage to smallest effective amount to pr clude development of ataxia, oversedation confusion (not more than two capsules per d initially; increase gradually as needed and tole

or here.

d). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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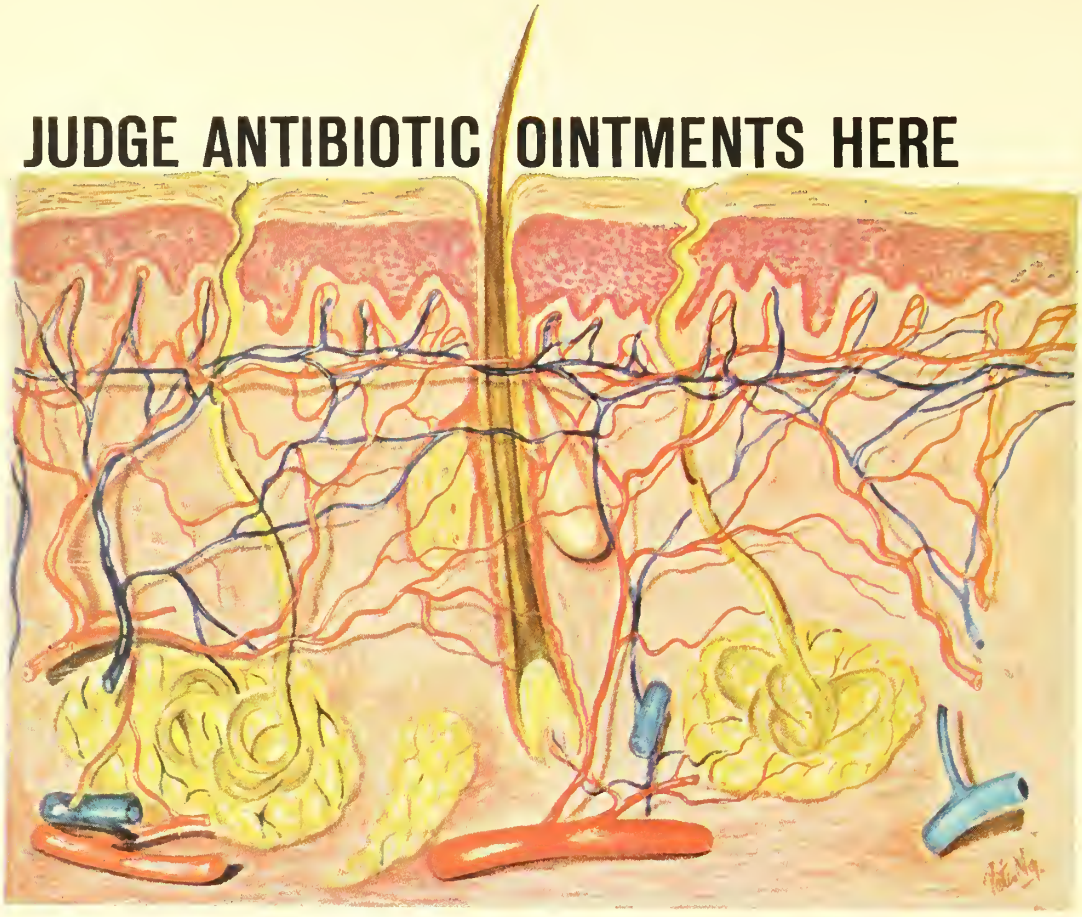

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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Students Receive Health Careers Exposure

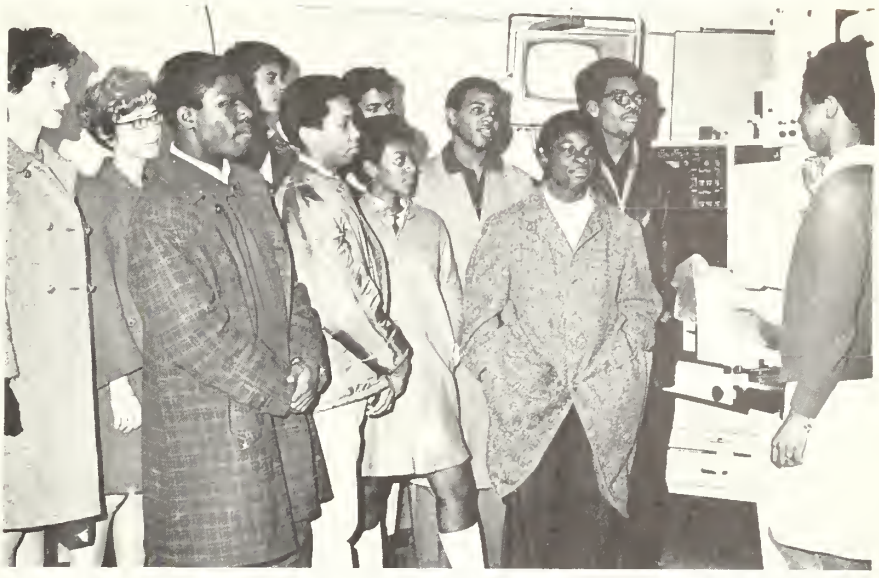
Hospitals Seek Prospects Among The Disadvantaged

Students throughout Pennsylvania from the junior high school level through college are being exposed to the idea of finding a career in the health field as a result of efforts of hospitals throughout the state. The hospitals are not limiting their programs to highly advantaged students, but are, in fact, seeking to introduce the health field to the disadvantaged for their consideration in seeking a way of life, of service, and of making a livelihood in the future.

Hahnemann Medical College and Hospital, Philadelphia, instituted a special summer program for thirty disadvantaged high school students, Dean Joseph R. DiPalma, M.D., has announced. "This opportunity will parallel the program for high ability high school students which Hahnemann has been conducting for many years. We have recruited students for this program from schools with high concentrations of disadvantaged students, in cooperation with the board of education. Scholarship was not the major criterion for admission to the program, but rather we focused on the degree of impoverishment, the home background and the school's evaluation of the potential promise of the candidate."

Dr. DiPalma stressed that this is not a service oriented program, although the students will work part of the time. "We hope to encourage as many of these students as possible to seek health profession careers consistent with their interests and abilities," Dr. DiPalma said. He added that much of the time this group will be working with the high-ability high school students, and the college and medical school students who are all in special summer programs at Hahnemann. They will attend some of the same lectures, but will also be exposed to

(Continued page 26)



A youth group *from the 3–10 Club, a teenage recreation center in York, listen intently to Mrs. Margaret Scott, R.N., (right), a nurse specialist in the York Hospital's cardiac diagnostic laboratory. Mrs. Scott explained to the teenagers how the sophisticated equipment used can help determine the presence or absence of heart disease. The club is sponsored by the Junior League of York. In the front row (left to right), Cecil Johnson, Beaver Jones, Veronica Bailey and Benjamin A. Green. Standing in the back row (left to right) are Mrs. Henry Wirts and Mrs. H. Milton Steinhauser, Jr., members of the Junior League; Charles Hawkins, Jim Clark, Larry Richardson and Dale Preston.*

Lankenau Researches Ultimate In Automated, Computerized Hospital

Lankanau Hospital in Philadelphia and the electronics firm of Honeywell, Inc. have joined forces to achieve the ultimate in automation and computerization of a hospital. The three-year project calls on the hospital for the setting and the medical expertise, and on Honeywell Test Instruments Division for the electronics experts and about $100,000 a year to finance the operation, which has as its goal providing better patient care at lower cost.

In announcing the "partnership in health" spokesmen for the hospital and the company said they envisioned the day when "doctors would be able to talk to a computer" and obtain information on precedent cases from a large data bank to assist in pinpointing a particular disease.

The long-term goal is to develop a coordinated, highly automated and efficient electronic system to do everything from telling a nurse when to administer medication and helping a doctor with a diagnosis to billing patients and keeping inventories of supplies. Gilbert R. Barnhart, Ph.D., assistant director for program planning and evaluation at the National Center for Health Services Research and Development of the Department of Health, Education, and Welfare, said of the venture that it might well be "the genesis of a new order" in the field of delivering health services."

The project was outlined by spokesmen for Lankanau and Honeywell, Inc. at a recent press conference and tour of

(Continued page 28)

newsfronts

Health Careers Grant Awarded to Temple

A federal grant of $68,816 has been awarded to Temple University Health Sciences Center to continue a pilot program called PRODIGY which guides teen-aged children from low income families into careers in the health field.

The grant supplied by the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare was announced by L. E. Burney, M.D., Temple vice president for health sciences.

Dr. Burney said the funds will expand PRODIGY for another year and will lay the foundation for a new program, Health Careers Opportunities Program (HCOP).

PRODIGY was started a year ago and has given 29 students on-the-job training with health professionals in fields such as social work; psychology; physical, occupational, and speech therapy; nursing; biomedical engineering; pulmonary function and medical communications. Under the program the student trains full-time during the summer but only ten hours a week during the school semester.

Theme Is Education

Fiske Prize Essay Deadline Announced

The trustees of America's oldest medical essay competition, the Caleb Fiske Prize Essay of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Medical Education In The Years Ahead." The essay must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of $500 is offered. Essays must be submitted by December 15, 1969.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.

HEALTH CAREERS/continued from P. 25

a great deal of special material designed especially for their needs. Victor P. Satinsky, M.D., associate professor of surgery, who created the initial high school program at Hahnemann, is director of this program as well.

Dr. DiPalma announced that Robert McMichael, a senior laboratory technician in the department of pharmacology, has been named special advisor to the thirty students. A graduate of Lincoln University, he has been employed at Hahnemann since 1956, and was cited as "employee of the year" this past December.

Believing in "getting them while they are young," Harrisburg Hospital, in the capitol city, has been conducting a "work and learn program" for thirty students from the eighth grade of two of the city's junior high schools during the second semester of this school year. W. S. Shakespeare, administrator of Harrisburg Hospital, said, "We are pleased and proud to participate in this program, and to help these students gain insight into the various health professions."

The students spent four hours per week in the hospital. Once a week they came together for a two-hour education program on an allied health career. The other two-hour period each student spends with a preceptor, with students and preceptors rotated each week to give students the widest exposure to the various health careers. The youngsters have not been involved in direct patient care but rather have been working in eleven supporting departments in the hospital.

Raymond W. Clugh, executive director of the Pennsylvania Health Council, stated that the objective of the program is "to expose to as many pre-selected students as possible the advantages of going into a health career following graduation from high school. Exposure to job opportunities at this age level may affect their choice of high school curriculum and thus provide further guidance for the future."

A similar program has been conducted at a Philadelphia hospital by the Pennsylvania Health Council with very favorable results.

Meanwhile, back in Philadelphia, the laboratory scene at the University of Pennsylvania has become the after-school scene for a group of high school students, many of whom are from minority groups or ghetto areas. There they have been learning their way through a maze of equipment and scientific lingo, and, with the help of white-coated scientists, working on ongoing biomedical research projects. Here again the students actually are involved in research projects, with the aim of giving the students a realistic introduction to career possibilities in the health professions and to motivate them toward the education necessary for these careers.

A medical research program in the biological sciences is beckoning to a select group of young collegians at Albert Einstein Medical Center. Limited to eight students who have completed their junior year in college, the program is one of work and study, and offers a grant-in-aid of sixty dollars a week. The students will be involved in full-time research in the departments of biochemistry, cellular biology, microbiology and biophysics, under the guidance of department heads and members. The program is supported by the National Science Foundation.

At the same time and in the same institution twelve high school seniors to-be are being given a chance to work and study with senior research investigators, in a program aimed at having them live and work as scientists for the summer. The program includes laboratory research, lectures, seminars and library research.

These programs, and similar ones in hospitals throughout the state, are providing information on health career opportunities to many hundreds of young people who might otherwise never know of the opportunities.

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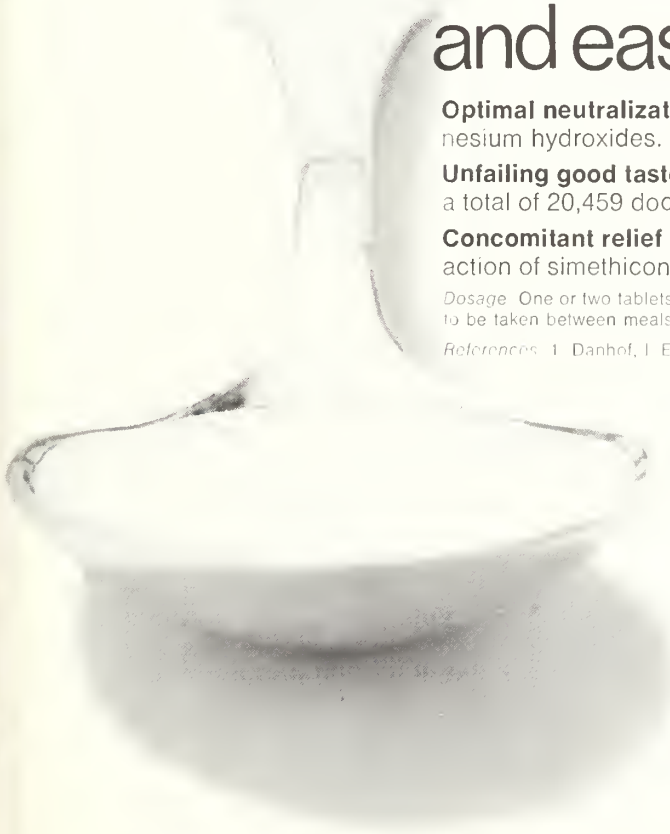
References 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.



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Pa. Hospital To Honor Noted Oral Surgeon

Pennsylvania Hospital, Philadelphia, will name its oral surgery clinic in memory of James Ritchie Cameron, D.D.S., who died in February. The prominent Philadelphian developed the hospital's section on oral surgery and served as chief of department for more than forty-two years.

Born in Brisbane, Australia, Dr. Cameron was graduated in 1914 from the University of Pennsylvania School of Dentistry.

PSIM Officers Named

James A. Collins, Jr., M.D., director of the department of internal medicine, Geisinger Medical Center, Danville, has been installed as president of the Pennsylvania Society of Internal Medicine, succeeding Robert S. Pressman, M.D., Philadelphia.

Other officers elected include: William J. Kelly, M.D., Pittsburgh, president-elect; Peter L. Saras, M.D., Hazleton, treasurer; and Raymond C. Grandon, M.D., Harrisburg, secretary.

New executive secretary of the state society is William B. Harlan, Harrisburg.

Education Fund Check Presented

Dean Francis S. Cheever, M.D., *center, of the University of Pittsburgh School of Medicine, receives a check for $11,636.02 from Mrs. Joseph B. Griffith, immediate past president of the Allegheny County Medical Society Auxiliary, left, and Robert J. Carroll, M.D., president of the Allegheny County Medical Society, right. The check is a portion of $63,276.58 distributed by the AMA Education and Research Foundation to seven Pennsylvania medical colleges. The money comes from voluntary contributions of doctors and auxiliary members. In addition, state physicians provided $152,900 in aid to 166 medical students in Pennsylvania in the '68-'69 school year through the PMS Education and Scientific Trust.*

LANKENAU/continued from P. 25

the hospital, followed by a luncheon at which Dr. Barnhart was the main speaker. Lankanau has established a new department, management information systems, whose director, Arthur S. Stankovich, has served in a variety of managerial and technical systems positions in industry. He and Angelo P. Angelides, M.D., coordinator of the division of professional activities for the hospital, presented Lankanau's reasons for launching such a program. Corles M. Perkins, vice president and general manager of Honeywell's Test Instruments Division, spoke for the company.

Based on studies already made, Lankanau is developing at present an acute medical intensive care unit with a coronary care sub-unit through the systems approach.

This effect is viewed as a first step in the development of patient care information-decision-action systems in the cardiovascular area including: cardio-pulmonary lab, heart station, inhalation therapy, ergocardiography, catherization lab, cardiac clinic.

The ultimate objective is to develop integrated, cost-effective patient care information-decision-action systems for all divisions of the hospital.

An organized and systematic approach to the design and development of patient care information-decision-action systems, hospital spokesmen said, begins with structuring what is known medically about the information-decision-action aspects of the disease process to be accommodated. It is this medical knowledge that is required to specify men, equipment and facilities needed. Accordingly, management information systems at Lankanau has, through the division of medicine, initiated an effort to structure the required medical knowledge. This effort will continue throughout the study.

There is much that is known about the pertinent disease processes. However, much remains to be known. This leads to the patient-care research aspects of the information systems. The over-all system is viewed as being composed of two functional sub-systems —a patient care sub-system and a patient care research sub-system. The objective of the latter is to make known what is not known today about the disease processes. Thus, the outputs of the patient care research sub-system will be the basis on which the patient care sub-system is developed and improved over time. Further, since, in general, the disease events can take place with great rapidity, and, since the data necessary to make decisions about these events is complex, it is logical that the information systems should be oriented from the beginning toward computer processing of the data and even toward computer control of some of the medical actions.

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Jeff Achieves University Status

Jefferson Medical College of Philadelphia which has been granting medical degrees since 1824, formally became a university, Thomas Jefferson University, on the first day of this month.

The charter was granted by Presiding Judge Vincent A. Carroll. Components of the university will be Jefferson Medical College, the College of Allied Health Sciences, the College of Graduate Studies, and Thomas Jefferson University Hospital.

Jefferson has been granting M.S. and Ph.D. degrees, besides the M.D. degree, for the past twenty years. The College of Allied Health Sciences is establishing a baccalaureate program to grant bachelor degrees in many paramedical fields, such as nursing, medical technology, x-ray technology, physical therapy and occupational therapy, according to James M. Large, chairman of the board of directors of the new university.

New in Philadelphia

The new *Medical Education Center of the Hahnemann Medical College and Hospital which will rise on the site of the former medical college and nurses' residence in Philadelphia.*

Pa. Community Services Group Studies Poverty, Inequality, Conflict

Poverty, inequality and conflict—obstacles and answers, provided the themes for various group discussions at the annual meeting of Community Services of Pennsylvania held recently in Philadelphia.

Among physicians who participated in the special interest sessions was PMS President George E. Farrar, Jr., M.D., who served as chairman of the session on Pennsylvania's New Health Care Approaches in Rural and Urban Settings. Serving with him in leading the panel discussion were: Patrick Storey, M.D., Philadelphia, chairman, department of community medicine, Hahnemann Hospital; Albert L. Chapman, M.D., M.P.H., director, bureau of planning evaluation and research for the Pennsylvania Department of Health, and J. Mostyn Davis, M.D., Shamokin, chairman, professional advisory committee, Rural Health Demonstration Project.

Nearly 600 health and welfare leaders from throughout the state attended the one-day session, and heard the chief speaker, Whitney M. Young, Jr., executive director, National Urban League call for an end to the ignoring of ghetto problems and the placing of more negroes, and more of the nation's poor, on the boards of agencies which are attempting to solve the problems of poverty, inequality and conflict. This, he said, is the only way to make such agencies truly effective.

PMS Developing Viet Nam Duty Awards

The Advisory Committee on Professional Relations of the PMS Council on Public Service is currently studying various means of developing a formal recognition to the many Commonwealth physicians who have voluntarily served under the Viet Nam program and other similar projects for medically substandard areas of the world.

At the present time, there is no formal state level acknowledgment of these highly laudable services performed by Pennsylvania "Docs" such as those awarded by the AMA specialty groups and other state societies.

Nevada To Build First Medical School

The Commonwealth Fund, a philanthropic foundation in New York City, has awarded a grant of $418,078 to the University of Nevada to help complete planning and found a School of Medicine on the University's Reno campus.

Pouring Fete Held For New $34 Million Hahnemann Medical Education Center

Foundation pouring ceremonies were held for the new $34,000,000 Medical Education Center at Hahnemann Medical College and Hospital, Philadelphia, May 5, at the site of the old college building. Charles S. Cameron, M.D., president, poured the first concrete into the foundation from a 9 cubic yard truck. 800 additional truck loads will be required to complete the foundation.

The new structure will have an 18-story tower and two ten-story wings. In its 14 acres of floor space will be housed 1200 rooms including 250 laboratories for teaching and research, 50 conference rooms and classrooms, 60 environmentally controlled rooms, 80 special purpose rooms, 50 animal rooms, and 400 faculty and research offices as well as a library, closed circuit television studio and 100 strategically placed television monitors for teaching purposes, three lecture halls and an auditorium. The building will be used exclusively for medical education and medical research. When the new Medical Education Center is completed in 1973 , it will permit Hahnemann to increase the size of its medical college class to 135 students.

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Program's 1st Stage Activated By SVRMP

A grant of $616,075 has been awarded to the Susquehanna Valley Regional Medical Program to activate the first stage of the Region's operational programs in heart disease, cancer, stroke and related diseases, it was announced by Raymond C. Grandon, M.D., of Harrisburg, chairman of the Program's Regional Advisory Group.

The grant, from the Division of Regional Medical Programs, U.S. Department of Health, Education, and Welfare, will support nine projects concerning coronary and stroke care, home health services, specialized training of nurses and continuing education of physicians, and will continue to support the costs of administering the program through its core staff. See details on page 37.

Announcement of the grant award comes less than two years after the SVRMP received its initial planning grant to study the twenty-seven county region's medical resources, identify needs and propose projects to alleviate these needs, thus providing better patient care for persons suffering from heart disease, cancer, stroke and related diseases.

It was not until early 1968, however, that a staff was recruited and planning was begun in earnest, utilizing the expertise of the region's physicians, hospital administrators, public health officials, and other health workers.

Director Richard B. McKenzie explained that the improvements in patient care are being planned without interfering with the existing patterns of medical care through voluntary cooperative arrangements of medical and allied personnel and the public.

Even though SVRMP is now operational, McKenzie said, the process of planning goes on indefinitely. Through the efforts of the geographical and categorical disease groups which have been functioning throughout the region, efforts are continuing to develop proposals which will strengthen medical care by providing the link between medical knowledge and the application of this knowledge to patient care.

M.D.'s Receive Teacher Awards

Harry E. Bacon, M.D., Philadelphia, *delivered the George E. Kunkel memorial lecture at the Harrisburg Hospital annual Doctors' Day, and received a citation from Clarence E. Moore, M.D., second left. Receiving the "distinguished teacher award" were R. Stanley Banks, M.D., right and Joseph B. Bittenbender, M.D., second right. The latter award was presented by Sidney Wedmore, M.D., representing the hospital's intern class, which selected them for the honor. Dr. Bacon is professor and head of proctologic surgery, Temple University Health Sciences Center. Dr. Bank is chief of medical service at Harrisburg Hospital, and Dr. Bittenbender is chief, section of neurology, department of medicine, at Harrisburg.*

Brain Damaged Children to Study

Harrisburg Hospital School Opens

The Harrisburg Hospital Medical Education and Research Foundation has announced the opening of a new educational facility for children with learning disabilities, Gary L. Ellis, foundation director, has announced.

The school is the only private facility of this type in the central Pennsylvania area. Although formal opening took place early in 1969, the school already has been licensed by the state department of public instruction. Initial financing came from a grant to the Research Foundation from the Vance C. McCormick Fund. Tuition is based on a sliding fee scale.

Director of the school is Miss Marian Metz, education coordinator for the hospital. Dr. L. Kathryn Dice, head, department of psychology, is program advisor.

Dr. Dice defined the objective of the school as "to initiate and strengthen the basic skills necessary to satisfactory progress in a regular grade. The learning disability in a child is due to mild cerebral damage which manifests itself in visual, auditory or motor skill deficiencies. Such deficits occur in children in all ranges of ability. For the present, children of average or above average potential are participating in the pilot program."

Prior to consideration for enrollment in the school, the child must be diagnosed as brain-injured through neurological and psychological examinations.

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REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

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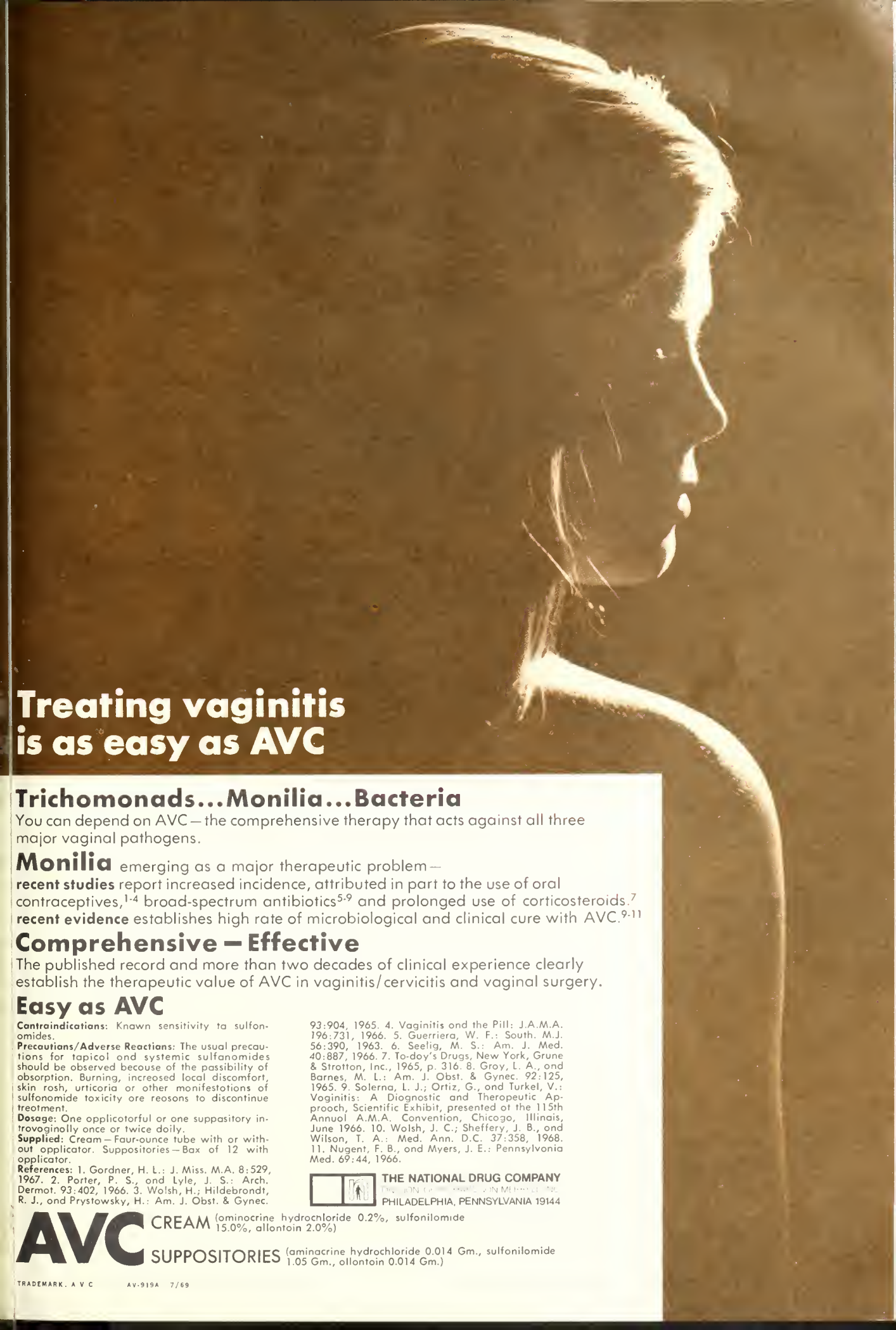

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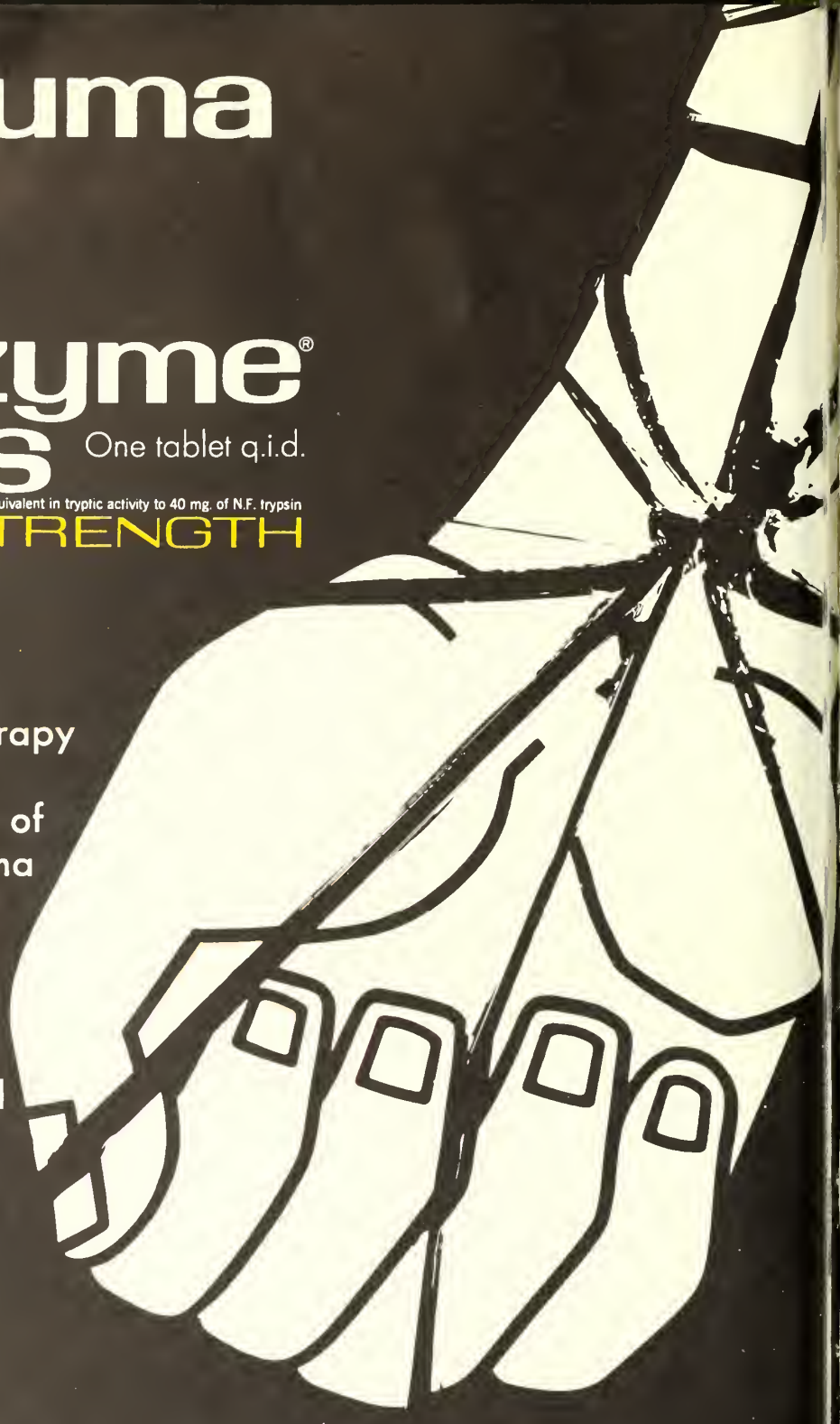

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Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

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Susquehanna Valley Regional Medical Program

DEVELOPMENT OF CORONARY CARE RESOURCES

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SUNBURY COMMUNITY HOSPITAL, SUNBURY—$13,215—Support for the cost of renovating and equipping three-bed CCU; training of physicians and six nurses in coronary care. Project Directors: Lawrence Kopf, M.D., and Thomas Savidge, M.D.

SHAMOKIN STATE GENERAL HOSPITAL, SHAMOKIN—$10,588—Support for the cost of equipping a three-bed CCU; training of physicians and four nurses in coronary care. Project Director: J. Robert Vastine, M.D.

GOOD SAMARITAN HOSPITAL, POTTSVILLE—$15,382—Support for the cost of additional equipment for hospital's CCU; training of physicians and nine nurses in coronary care. Project Director: Norman Wall, M.D.

BEDFORD COUNTY MEMORIAL HOSPITAL, EVERETT—$24,154—Support for the cost of renovating and equipping a four-bed CCU; training of physicians and six nurses in coronary care. Project Director: Theodore Baranik.

GEISINGER MEDICAL CENTER, DANVILLE—$17,298—A four-week training program in coronary care for twenty nurses from nearby hospitals. Project Directors: Charles A. Laubach, Jr., M.D., and Mrs. Emma Jean Knapper, R.N.

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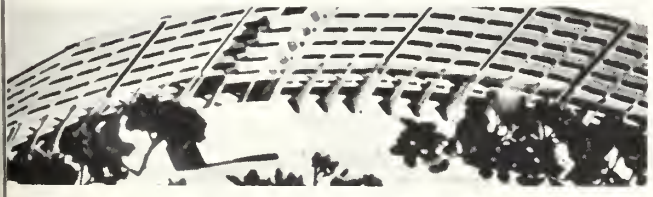

HERSHEY MEDICAL CENTER, HERSHEY—$28,309—Dissemination of medical information and materials, upon request, including copies, loan of "hard copy," literature searches, and short courses for hospital library staffs. The amount funded is for the first year; the project was approved for three years. Project Director: Fred D. Bryant.

INTENSIVE STROKE CARE UNIT

MERCY HOSPITAL, ALTOONA—$59,039—Support for an eight-bed unit for the acute, intermediate and rehabilitative care of the stroke patient; also to be used as a training facility for physicians, nurses and ancillary personnel. Project Director: Sister Margaret Mary.

SUSQUEHANNA VALLEY HOME HEALTH SERVICES, INC.

SNYDER, UNION AND NORTHUMBERLAND COUNTIES—$39,556—Home health care services to persons in Snyder, Union and northern Northumberland Counties, including in-the-home skilled nursing care and rehabilitation education and services, and training of home health aides and homemakers. Project Director: H. Eugene Smith.

close-up/MD's

Col. John B. Coates, Jr., (MC) Phoenixville, commanding officer at Valley Forge General Hospital, has been nominated for the rank of brigadier general, and will command the Army's Madigan General Hospital, Tacoma, Washington. His successor at Valley Forge has not been announced. Col. Coates is a native of Glenside, and attended Ursinus College. He received his M.D. from the University of Pennsylvania School of Medicine.

COL. COATES

Francis C. Jackson, M.D., a member of the PMS Commission on Education and Science and its Advisory Committee on Emergency Medical Services, was honored as the "Man of the Year in Medicine for 1969" by the Pittsburgh Academy of Medicine. The award was in recognition for "his many contributions to the health and welfare of the citizens of this community." Dr. Jackson is chief surgeon at the VA Hospital and professor of surgery at the University of Pittsburgh School of Medicine.

John L. Murphy, M.D., senior surgeon at Children's Hospital of Philadelphia, will be the Evan P. Helfaer Visiting Professor of Urology at Marquette University, Milwaukee, Wisc. from April 2-4. Dr. Murphy is professor of urology at the University of Pennsylvania School of Medicine.

Hans May, M.D., recently enplaned for retirement in St. Croix, Virgin Islands, bringing to an end an illustrious career in surgery. Longtime chief of Lankenau Hospital's department of plastic and reconstructive surgery, Dr. May was also associate professor of the Graduate School of the University of Pennsylvania School of Medicine. He has published three books and more than seventy articles. His writings are regarded world-wide as the highest authority on the subject of plastic and reconstructive surgery. A native of Germany, Dr. May received his M.D. from the University of Freiburg followed by a seven-year residency under Erich Lexer, M.D., one of the pioneers in plastic surgery, at the Surgical University Hospital at Munich. He came to the U.S. in 1934 and joined the Lankenau staff the following year. He became chief of the newly-created department of plastic and reconstructive surgery in 1953, a post he held until his promotion to senior consultant in 1967. He served as president of Lankenau's Medical Staff from 1966 to 1967.

Dr. Graham H. Jeffries, an authority on gastrointestinal and liver diseases and a former Rhodes scholar from New Zealand has been appointed professor and chairman of the department of medicine, Pennsylvania State University College of Medicine, Hershey. He is currently on the faculty at Cornell-New York Medical Center, where he is chief of the division of gastroenterology. His degrees, M.B. and Ch.B. from Otago Medical School at the University of New Zealand, are the equivalent to the M.D. degree. Additionally he earned a D. Phil. degree in experimental pathology while a Rhodes scholar at Oxford.

DR. JEFFRIES

H. Ford Clark, M.D., Huntingdon, was elected president of the Pennsylvania Academy of Ophthalmology and Otolaryngology at the association's recent convention. He succeeds **Harold G. Schie, M.D.,** Philadelphia. Also elected at the session were **Robert J. Beitel, M.D.,** Allentown, president-elect; **David Myers, M.D.,** Philadelphia, first vice-president; **C. William Weisser, M.D.,** Pittsburgh, second vice-president; **Ralph F. Himes, M.D.,** Altoona, third vice-president; and **Gerald M. Shannon, M.D.,** Philadelphia, **William W. G. McLaghlan, M.D.,** Erie; and **Franklin A. Bontempo, M.D.,** Rochester, directors. Re-elected to office were **Joseph A. Cipcic, M.D.,** Pittsburgh, secretary; **Bruce A. Grove, M.D.,** York, treasurer; and **Robert E. Shoemaker, M.D.,** Allentown, secretary.

DR. CLARK

David M. Davis, M.D., Bryn Mawr, is the first recipient of the American Urological Association's annual Hugh Hampton Young award for outstanding contribution to the study of infection of the genito-urinary tract. A gold plaque and an award $2,000 are made possible through a grant from Bristol Laboratories. Dr. Davis, emeritus professor of urology at Jefferson Medical College, and lecturer on the subject at the University of Pennsylvania School of Medicine, is co-author, with Dr. Young, of a textbook of choice on urology, as well as other books and papers on the subject.

M. Kianoury, M.D., Philadelphia, assistant in surgery at Albert Einstein Medical Center, delivered a paper entitled "Malignant Melanomas in the Gastrointestinal Tract," at a symposium at Tehran University Medical School in Iran.

Irvin Stein, M.D., Philadelphia, chairman of the department of orthopedic surgery, Albert Einstein Medical Center, delivered two papers at the Sixteenth Biennial International Congress of the International College of Surgeons, held in Tokyo, Japan. A third paper was delivered to the same group in Osaka.

William R. Host, M.D., Laceyville, recently was installed as president of the Community's Rotary Club. He will serve for the 1969-70 term.

John T. Dickinson, M.D., Pittsburgh, clinical associate professor of otolaryngology at the University of Pittsburgh School of Medicine, participated in the facial skin seminar which was offered recently at Cook County's Graduate School of Medicine, Chicago, Ill. Dr. Dickinson is chief of staff and chairman of the division of otolaryngology, Mercy Hospital, and chairman, section of head and neck surgery, and senior staff, Eye and Ear Hospital.

DR. DICKINSON

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Effectiveness confirmed by another double blind study*

1.SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
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Dose: 1 tablet 3 times daily

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Thyroid Ext. (½ gr.)	30 mg.
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REFER TO PDR

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Thiamine HCL	25 mg
Glutamic Acid	100 mg
Pyridoxine HCL	5 mg
Niacinamide	75 mg
Calcium Pantothenate	10 mg
Vitamin B-12	2.5 mcg
Riboflavin	5 mg

Dose: 2 tablet twice daily
Available: Bottles of 60, 500.

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg
Glutamic Acid	50 mg

INDICATIONS Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post operative and debilitating disease, osteoporosis. **DOSE** One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS** In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRAINDICATIONS** See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands

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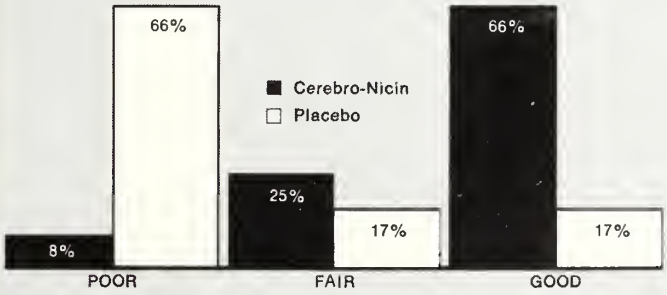

CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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For elderly patients
in need of a mild tranquilizer
consider **Tybatran**®
brand of tybamate

(When you consult
the Prescribing Information
you may agree
it makes good sense)

PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

close-up/MD's

WELCOME, NEW MEMBERS!

These M.D.'s have joined the State Society in recent months:

BERKS COUNTY:

ALBERT B. KOCHERSBERGER, M.D., 1650 Penn Ave., Wyomissing 19610.

BLAIR COUNTY:

WILLIAM L. BAIN, M.D., Mercy Hospital, Altoona 16603.

BRADFORD COUNTY:

JAMES H. WEEKS, M.D., Guthrie Clinic, Sayre 18840.

FRED S. WINTER, M.D., Pottstown Memorial Medical Center, Pottstown 19464.

CENTRE COUNTY:

DONALD E. MULHATTEN, M.D., 233 Easterly Pkwy., State College 16801.

DAUPHIN COUNTY:

RICHARD R. BROCK, M.D., Polyclinic Hospital, Harrisburg 17110.

SAMUEL E. MCLINN, M.D., 2800 Green St., Harrisburg 17110.

DELAWARE COUNTY:

HUGO F. RODRIGUES, M.D., Twenty-second and Chestnut Sts., Chester 19013.

JOHN J. BONGIOVANNI, M.D., 41 Brandon Rd., Upper Darby 19082.

ERIE COUNTY:

WILLIAM D. LOOSE, M.D., 4822 Wolf Rd., Erie 16505.

JOHN M. EDINGTON, M.D., 2084 Berkshire Lane, Erie 16509.

JOHN P. MRAZ, M.D., 225 W. Twenty-fifth St., Erie 16503.

FAYETTE COUNTY:

CATALDO F. CORRADO, JR., M.D., Uniontown Hospital, Uniontown 15401.

LUZERNE COUNTY:

JOSEPH M. LOMBARDO, M.D., 48 S. Main St., Pittston 18640.

MONTGOMERY COUNTY:

JOSEPH F. ALTAMONTE, M.D., 917 Fayette St., Conshohocken 19428.

BLANCA M. GOMEZ, M.D., Norristown State Hospital, Norristown 19401.

PEDRO F. GOMEZ, M.D., Norristown State Hospital, Norristown 19401.

JOHN M. RUSK, M.D., 354 Lancaster Ave., Haverford 19041.

HAROLD M. WEINER, M.D., 105 W. Walnut Park Dr., Philadelphia 19120.

LEWIS M. JACOBS, M.D., 10825 E. Keswick Rd., #80, Philadelphia 19154.

In the Commonwealth

Bill to Provide Malpractice Coverage Introduced

A bill which would make it mandatory that casualty insurance companies provide malpractice insurance to Pennsylvania physicians has been introduced into the House of Representatives, and was referred to the Committee on Consumer Protection July 9. The bill amends the Insurance Company Law of 1921 and states: "Every casualty company, association or exchange having a certificate of authority to do business in this Commonwealth shall insure, at reasonable premium rates, against medical and other professional health care malpractice."

The bill has teeth, in that if an insurance company refuses to comply with the amendment, the insurance commissioner may take action against the offending party by revoking the certificate of authority of the offending company; refusing, for a period not to exceed one year thereafter, to issue a new license to such offending company or imposing a penalty not to exceed $1,000 for each act of violation.

The bill, No. 1409, has bi-partisan support and was introduced by nine legislators.

Health Reorganization Plan Defeated

The House of Representatives rejected last month, by a vote of 192 to 2, the health reorganization plan presented in accordance with the reorganization act of 1955. The plan would have transferred all health functions now within the Department of Public Welfare to the Department of Public Health. The plan, Reorganization Plan No. 2, 1969, would have been adopted if neither the House nor the Senate disapproved within thirty days, and would have transferred the following health services, which are now in the Department of Public Welfare: Office of Mental Health and Mental Retardation, the office of Medical Services and Facilities, the Bureau of Medical Policies and Standards, the Bureau of Hospital Standards and Supervision, the Bureau of Medical Facilities Planning, the Bureau of Adult Institutions, the Bureau of State-owned Institutions and all of the state general hospitals, mental hospitals and restoration centers.

Governor Raymond P. Shafer said, "I find the rejection of the plan surprising, because so many members of the General Assembly have complained to me and to other members of my administration that something must be done to reform the present welfare system. One of the major reasons for proposing the plan was to isolate the welfare problems so that the Secretary of Public Welfafre could devote his full energy in the new year toward a reform of the system."

Proponents of the plan in the Legislature may now introduce legislation of a bi-partisan nature to accomplish the same purpose. Integration of the state's health services was recognized as necessary as far back as 1961 in a Johns Hopkins University study called "Pennsylvania's Health."

PMS has suported the reorganization to provide for integration of health services.

In the Nation

Hearings on Medicare and Medicaid Begin

The Senate Finance Committee has begun hearings on Medicare and Medicaid. First to testify were HEW Undersecretary John G. Veneman and Commissioner of Social Security Robert M. Ball. Mr. Veneman called for changes in the law recommending that Social Security have the authority to discontinue payments to practitioners who have shown a pattern of fraud, repeated overcharging or the use of supplies which are inferior or harmful. Commissioner Ball called increasing costs the primary problem of Medicare.

As the hearings proceeded, President Richard M. Nixon issued a statement that the country faced a "massive crisis" in the distribution of medical care, and announced a program of action to keep medical care costs down. Included are: eliminating the allowances to hospitals and nursing homes for "unidentified costs," stricter federal regulations limiting payments to individual practitioners under Medicaid, beginning July 1 of this year, and the establishment of a twenty-five man task force on Medicaid and related problems, to be chaired by Undersecretary Veneman.

The regulation limiting payments holds them to those received in January of 1969, except in states where payments were below the seventy-fifth percentile of customary charges at that time. Comments on the regulation may be made in the next thirty days before it is published as final policy.

★

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Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

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or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-254-3201

Sex

I recall reading a statement by a prominent British philosopher which claimed that the average man derives more pleasure from his water closet than from his wife. I suppose we may assume that this works two ways but like the male philosopher who made the statement, I will be obliged to let the ladies speak for themselves.

We are indebted to another thinker, this time our own Henry David Thoreau, for the statement that "The mass of men lead lives of quiet desperation." In this case we may be certain that Thoreau meant both men and women.

The remedy for the desperate circumstances of our lives certainly lies in greater knowledge and deeper understanding.

In the case of the first difficulty—our failure to love one another in the deepest and best marital sense—we are proud to be able to offer enlightenment. Dr. Paul Poinsard, professor of psychiatry at Jefferson Medical College, has brought us an essay which is capable of clearing up much of the ignorance which may surround our outlook on sexual function and dysfunction.

It is certain that any enlightenment we derive from this paper concerning the psycho-physiological process called sex will be a giant step in the relief of the desperate condition in which many of us lead our lives.

Turn to page 75 of this issue for Dr. Poinsard's illuminating essay.

CBL

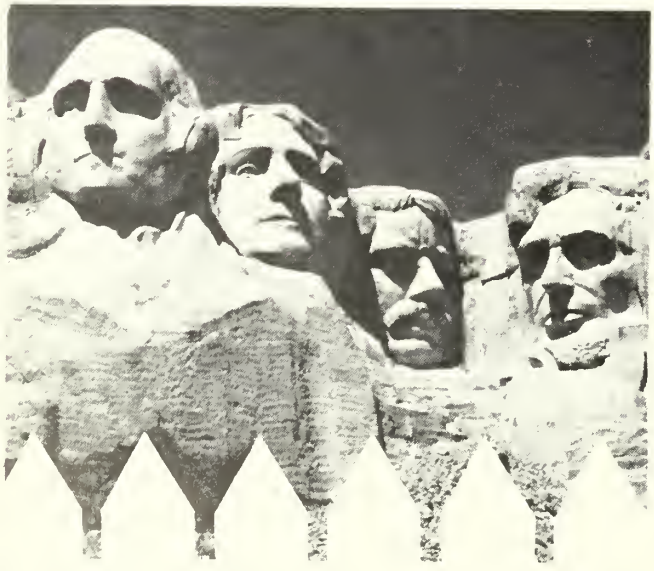
Use the Zip Code

One of the most progressive ideas initiated by the Federal Government in recent years is the zip-code system for mail addressing instituted and promoted by the Post Office Department. Consistently used, zip coding can speed delivery of mail and save money at the same time—a double bonus.

Physicians probably have a greater stake in seeing to it that zip codes are used consistently than almost any other segment of the population. The volume of mail to and from physicians, especially at statement time, heads the top of the list. The one-time effort to zip code all of the addresses that a physician uses can bring a tangible return.

The five-digit zip code can be machine-sorted in many of the larger post offices and speeded on its way with the fraction-of-a-second click of a solenoid. Mail without zip coding goes through a series of hand-sorting operations subject to human error and requiring a colossal memory or, more frequently, reference to routing charts. The time and cost savings become obvious if you watch the sorting operation in a major post office.

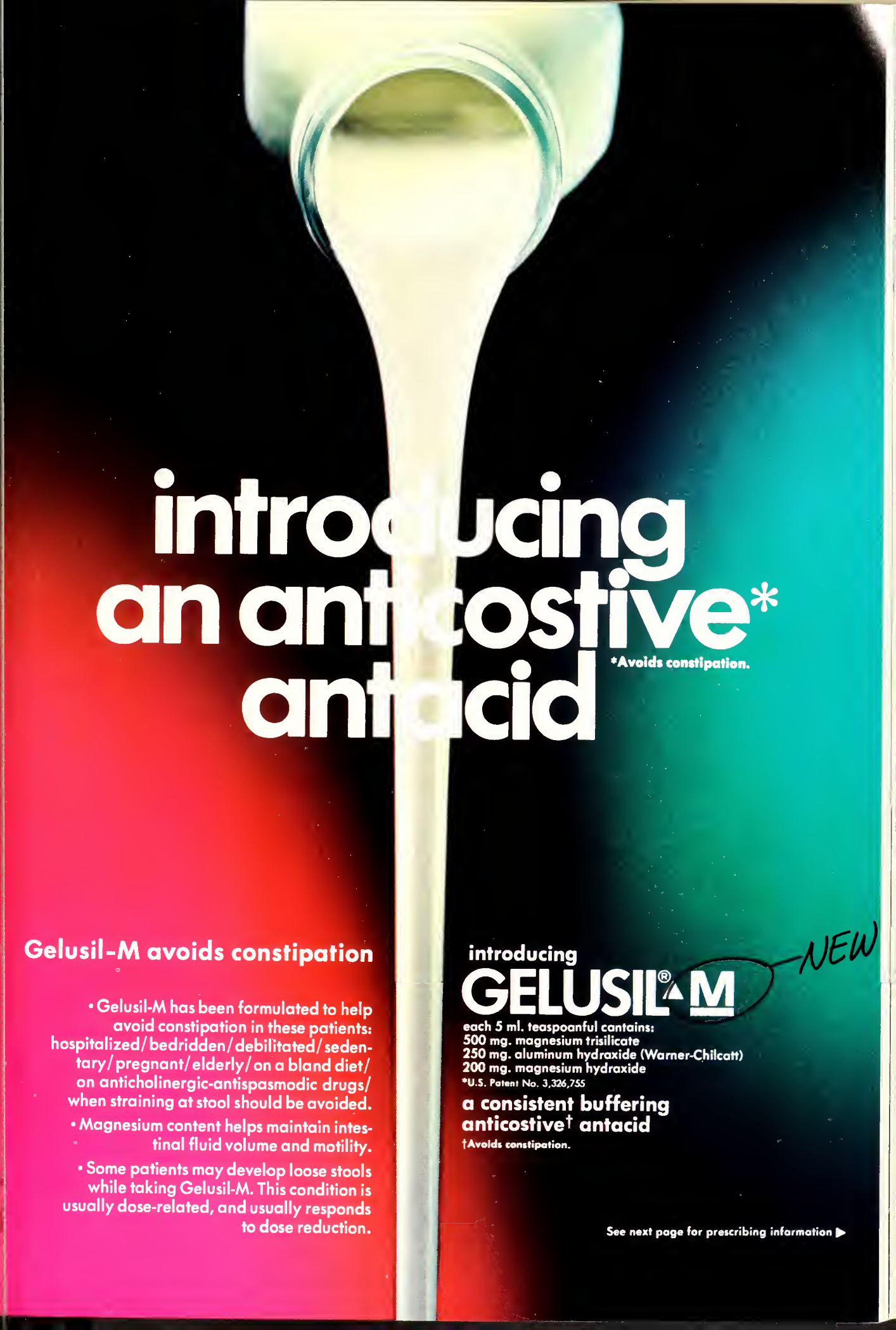
There are growing pressures for changes in the administration of our postal system and for changes in the system itself, but regardless of the direction these may take there seems to be no efficient substitute for zip coding. Using it is in the best interests of everyone.



Say hello to the boys next door.

People come from all over the world to discover the man-made and natural wonders of America. And you have a heck of a head start—it's all in your own backyard.

This year, discover America. Carve out a great vacation.



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*Avoids constipation.

Gelusil-M avoids constipation

- Gelusil-M has been formulated to help avoid constipation in these patients: hospitalized/bedridden/debilitated/sedentary/pregnant/elderly/on a bland diet/on anticholinergic-antispasmodic drugs/when straining at stool should be avoided.
- Magnesium content helps maintain intestinal fluid volume and motility.
- Some patients may develop loose stools while taking Gelusil-M. This condition is usually dose-related, and usually responds to dose reduction.

introducing

NEW

GELUSIL® M

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate
250 mg. aluminum hydraxide (Warner-Chilcatt)
200 mg. magnesium hydraxide
*U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

†Avoids constipation.

See next page for prescribing information ▶

GELUSIL–one name to remember...and a dosage form for every patien

Gelusil®-M Liquid

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

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CANCER FORUM

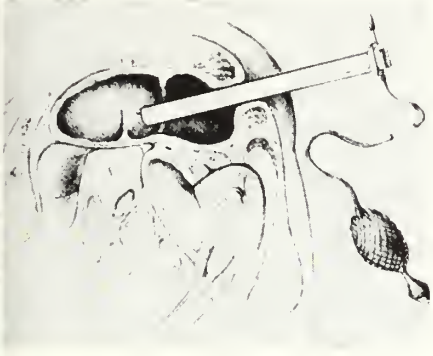
SAFEGUARD AGAINST COLON CANCER

Diagnosis Depends on the Digital, Procto and X-ray

DIGITAL

Use Knee-Chest or Sims Position.
Have Patient Strain During Examination.
Palpate the Entire Circumference of the Rectum.
Digital Examination Should Always precede the Proctoscopic.

PROCTOSCOPIC



Prepare Patient with Laxative and Enema.
Use Knee-Chest or Sims Position.
Disposable Proctoscopes are very Satisfactory.
Be Gentle. You want him to come Back.
Refer to Surgeon or Proctologist For Biopsy if Necessary.

X-RAY

Do X-Ray Study Even if Lesion is Found Lower.
Multiple Lesions are Common.
If X-Ray is Negative and Symptoms are Suggestive. Repeat Studies in Three Weeks.

ALL PATIENTS WITH HEMORRHOIDS MUST BE EXAMINED
MOST COLON CANCERS PRESENT WITH SYMPTOMS
DON'T BE RESPONSIBLE FOR DELAY

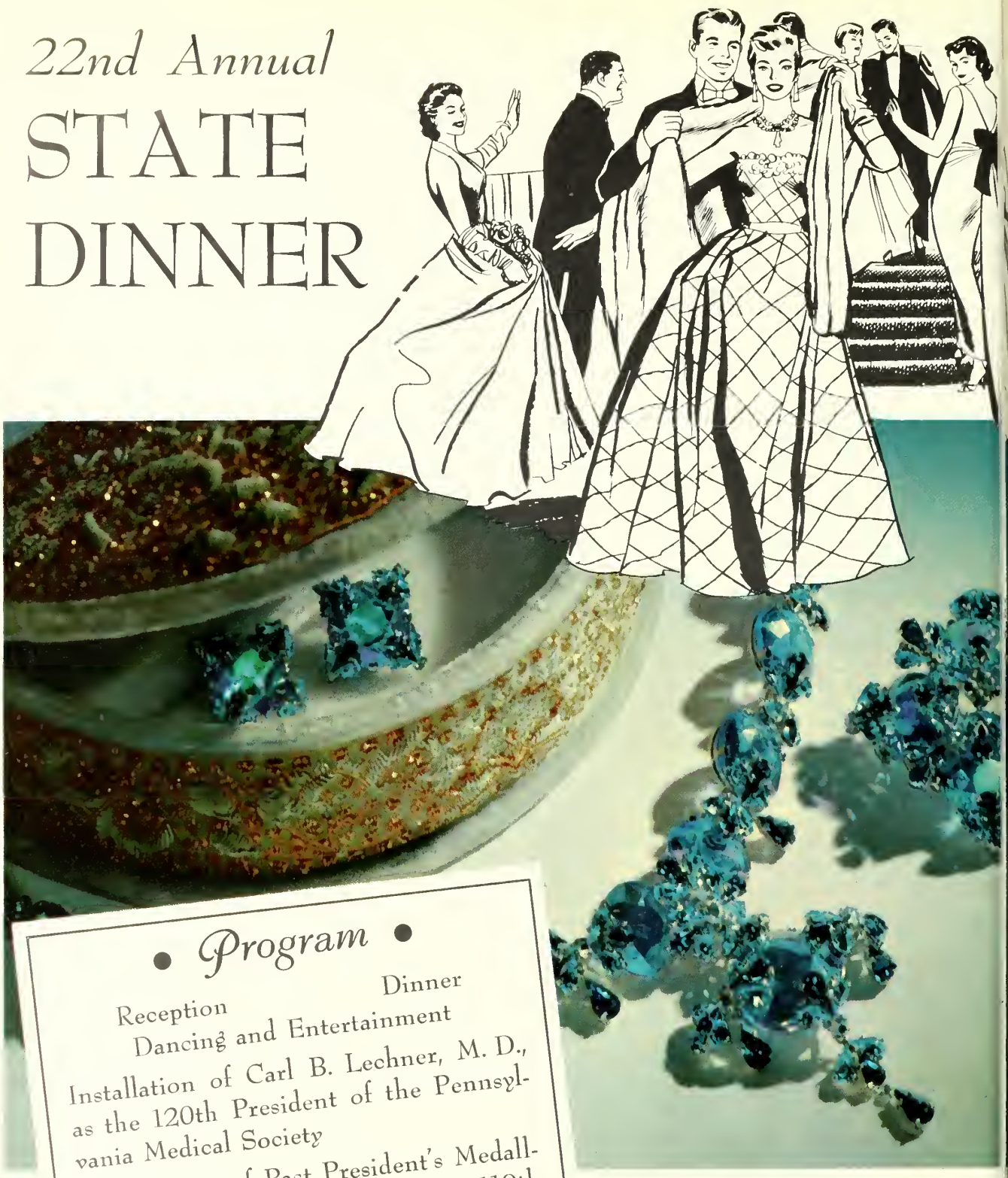
AMERICAN CANCER SOCIETY
Pennsylvania Division
Philadelphia Division

Consultant,
William Beck, M.D.
Chief, Dept. of Surgery
Guthrie Clinic
Robert Packer Hospital

Pennsylvania Cancer Forum Page—presented cooperatively by the Council on Education and Science of the Pennsylvania Medical Society, the Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health.

22nd Annual

STATE DINNER



• Program •

Reception
Dinner
Dancing and Entertainment

Installation of Carl B. Lechner, M. D., as the 120th President of the Pennsylvania Medical Society

Presentation of Past President's Medallion to George E. Farrar, Jr., M.D., 119th President

Tribute to Mr. Lester H. Perry, Retiring Executive Director, Pennsylvania Medical Society [1934-1969]

Presentation of the State Benjamin Rush Awards

FRIDAY EVENING
OCTOBER 10, 196
PHILADELPHIA MARRIOT
MOTOR HOTEL

Official Call to the
Annual Session of the House of Delegates

The 1969 Annual Session of the House of Delegates of the Pennsylvania Medical Society will convene in the Brandywine Ballroom of the Marriott Motor Hotel, Philadelphia, Pennsylvania at 7:30 p.m., Thursday, October 9, 1969. Subsequent meetings of the House of Delegates are scheduled for 9:00 a.m., Saturday, October 11, and 9:00 a.m., Sunday, October 12.

PROPOSED AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

Printed below is the text of the amendments to the Constitution and By-laws which are being proposed by the Committee on Constitution and By-laws.

Note: Material which is underscored is being added. Material which is enclosed in [brackets] is being deleted.

I. Subject: Amendment of membership provisions to permit qualified doctors of osteopathy to become Society members; clarification of affiliate membership provisions.

CONSTITUTION

Article IV—Membership

Amend Section 1 as follows:

Section 1—Definition.

As used in this Constitution, except as otherwise herein expressly qualified, [the terms "doctor of medicine" or "physician" mean a holder of the degree of Doctor of Medicine or Bachelor of Medicine fully licensed to practice medicine] the term "physician" means a Doctor of Medicine, a Bachelor of Medicine, a Doctor of Osteopathy, or other person holding an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania.

Amend Section 2 as follows:

Section 2—Active Member.

The Active Members of this Society shall be [doctors of medicine] physicians who are members of the Component Societies.

Amend first sentence of Section 3 as follows:

Section 3—Senior Active Member.

A Senior Active Member of this Society shall be a [doctor of medicine] physician, who (i) is not an Associate Member hereof, (ii) is sixty-five years of age or over, and (iii) has been an Active Member of this Society, a service member of the American Medical Association, or an active member of a constituent association of the American Medical Association for a continuous term of not less than thirty years.

Amend first sentence of Section 4 as follows:

Section 4—Associate Member.

An Associate Member of this Society shall be a [doctor of medicine] physician who (i) is seventy years of age or over and (ii) has been an Active or Senior Active Member of this Society, a service member of the American Medical Association, or an active member of a constituent association of the American Medical Association for a continuous term of thirty years.

Amend first sentence of Section 5 as follows:

Section 5—Affiliate Member.

Upon recommendation and certification in due form by the Component Society to and election by the Board of Trustees and Councilors, any member of a Component Society may be made an Affiliate Member of this Society and remain as such provided he is a person who belongs to one of the following classes: (a) persons who are members of national medical societies of foreign countries; (b) American [medical doctors] physicians engaged in medical missionary [, educational] or philanthropic labors; (c) persons who are eligible to be service members of the American Medical Association; (d) full-time teachers of medicine or of the arts and sciences allied to medicine who are not holders of [the degree of Doctor of Medicine or Bachelor of Medicine] an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania; (e) [doctors of medicine] physicians not fully licensed to practice medicine in Pennsylvania who are engaged in Pennsylvania in research, public health, administrative medicine, or hospital residency, and (f) [doctors of medicine] physicians, whether or not fully licensed to practice medicine in Pennsylvania, who are retired from active practice. Affiliate Members shall not be required to pay any annual assessment.

Amend first sentence of Section 6 as follows:

Section 6—Honorary Member.

Any [doctor of medicine] physician not a resident of Pennsylvania but a member of his own state or territorial medical association may be elected an Honorary Member of this Society by the House of Delegates by a three-fourths vote at any Annual Session.

BY-LAWS

Chapter I—Membership

Amend Section 1 as follows:

Section 1—Definition.

In conformity with the Constitution of this Society, [the terms "doctor of medicine" or "physician" respectively,] the term "physician" as used in these By-laws, except as otherwise expressly qualified in the Constitution in any particular related provision, [mean a holder of the degree of Doctor of Medicine or Bachelor of Medicine fully licensed to practice medicine] means a Doctor of Medicine, a Bachelor of Medicine, a Doctor of Osteopathy, or other person holding an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania.

II. Subject: Clarification of By-law provisions regulating reinstatement of a member who is delinquent in paying his annual assessment.

BY-LAWS

Chapter I—Membership

Amend first sentence of Section 3 as follows:

Section 3—Admission to Membership.

Every member of a Component Society eligible to become an Active Member or a Senior Active Member of this Society shall [automatically] become such upon receipt by the office of the Executive Director of the certification and assessment required by Section 4 of Chapter XVI of these By-laws. Every member of a Component Society eligible to become an Associate Member of this Society shall [automatically] become such upon receipt by the office of the Executive Director of the certification required by Section 4 of Chapter XVI of these By-laws.

Amend Section 5 as follows:

Section 5—Termination of Membership.

The membership of a member of this Society shall terminate (a) [automatically] upon (i) termination of his membership in his Component Society for any reasons whatsoever, or (ii) failure to pay a delinquent assessment within thirty days after notice of such delinquency as provided in Section 2 of Chapter IX of these By-laws, or (iii) three months after ceasing to be eligible for membership herein in the class of membership in which he is a member as specified in the Constitution, unless at such time an application or certification for another class of membership for which the member will become immediately eligible is pending in the office of the Executive Director of this Society, and (b) upon the effective date, as provided in Section 7 of Chapter XIII of these By-laws, of an order to that effect issued by the Judicial Council of this Society. Any person whose membership has been terminated for failure to pay a delinquent assessment shall be [automatically] reinstated to membership without any break in continuity of membership upon payment of the delinquent assessment in full before December 31 of the assessment year and reinstatement by his component society, but no such member under any circumstances shall be considered to be an Active or Senior Active Member in good standing during the period between January 1 of the year for which the assessment was delinquent and the date of reinstatement for the purposes of any section of the Constitution or these By-laws.

Amend Section 6 as follows:

Section 6—Suspension from Membership.

The membership of a member in this Society shall be suspended (a) [automatically] upon suspension of his membership in his Component Society, and (b) upon the effective date, as provided in Section 7 of Chapter XIII of these By-laws, of an order to that effect issued by the Judicial Council of this Society. The suspended member shall not be entitled to exercise any of the rights or privileges of membership during the period of suspension, shall be required to continue the payment of annual assessments without any reduction whatsoever, and shall be restored [automatically] to full membership upon the expiration of the period of suspension.

III. Subject: Providing the President of each SAMA Chapter in Pennsylvania with a seat in the House of Delegates, including the right to vote, serve on reference committees, and introduce resolutions.

CONSTITUTION

Article IV—Membership

Insert a new Section 7, as follows:

Section 7—Special Student Member.

The President of each Active Chapter of the Student American Medical Association in the medical schools of the Commonwealth of Pennsylvania shall be a Special Student Member. Special Student Members shall not be required to pay any annual assessment.

[*Section 7*] *amended to become Section 8, and amended as follows:*

Section 8—Rights and Privileges of Members, Including Voting Rights.

All members of the Society shall have all of the rights and privileges of membership except as otherwise provided in this Constitution and the By-laws and except that neither Associate nor Affiliate nor Honorary Members shall have the right to vote or hold any office or to be members of any council, committee, or commission.

Each Special Student Member shall serve as a delegate in the House of Delegates with the right to vote and to serve on reference committees, with the exception of the Reference Committee on Constitution and By-laws; but no Special Student Member shall have the right to hold any office or to be a member of any council, commission, or committee.

No member of this Society of any class shall have any direct vote in the affairs of this Society except as to such matters, if any, where such vote is required by the laws of the Commonwealth of Pennsylvania.

[*Section 8*] *amended to become Section 9.*

Article VI—House of Delegates

Amend Section 2 as follows:

Section 2—Composition.

The House of Delegates shall be composed of (a) delegates (or their alternates) elected by the Component Societies in the proportion of one delegate for every one hundred or fraction thereof of its Active and Senior Active Members in this Society whose dues are paid or excused as of December 31 of each preceding year, whose term of office shall be for a term of one year or for a term in excess of one year if such Component Society's By-laws provide for a longer term than one year provided that at least one delegate or alternate be elected by such Component Society each year, and whose names have been submitted to the office of the Executive Director of the Pennsylvania Medical Society as instructed by the Executive Director, and in January of each year the Executive Director of the Pennsylvania Medical Society shall certify to each Component Society the number of delegates to which it is entitled during the current year; (b) the secretaries of the Component Societies in office at the time of any meeting of the House of Delegates; (c) special student members (or their alternates) as defined in Sections 7 and 8 of Article IV; and [(c)] (d) ex-officio, but without the right to vote, the Speaker and Vice-Speaker of the House of Delegates, the President, President-elect, the Vice-Presidents, the Secretary, the Trustees and Councilors, and the member of the Judicial Council of this Society, the ex-presidents of this Society and the presidents of the Component Societies, except that any of the foregoing ex-officio delegates, other than those prohibited from so doing by Article V of this Constitution, may at the same time serve as voting delegates duly designated as such by

the respective Component Societies, and except that the Speaker, or the Vice-Speaker when serving as Speaker, shall have the right to vote in all cases where his vote would change the result of a vote taken other than a vote decided by ballot.

Add a new fourth paragraph to Section 3 as follows:

SECTION 3—ALTERNATES.

If any special student member is unable to serve he may designate an alternate to serve in his place from the active membership of his Chapter of the Student American Medical Association.

BY-LAWS

CHAPTER III—HOUSE OF DELEGATES

Insert a new second sentence in Section 4, as follows:

SECTION 4—CREDENTIALS OF DELEGATES.

Prior to the opening of any session of the House of Delegates, each voting delegate and each alternate delegate shall deposit with the Committee on Credentials a certificate signed by the President and Secretary of the Component Society, or any two officers thereof duly authorized by its governing board to sign such certificates, under the seal of the same, stating that he has been legally and regularly designated as a voting delegate or alternate delegate to this Society. Each Special Student Member or his alternate shall deposit with the Committee on Credentials a certificate signed by the Secretary of this Society under the Society's seal which states that he is the duly certified representative of his Chapter of the Student American Medical Association.

ELECTIONS

Among the general officers to be elected by the 1969 House of Delegates will be:

A President-Elect, four Vice-Presidents, a Secretary, a Speaker of the House of Delegates, and a Vice-Speaker of the House of Delegates.

A Trustee and Councilor for the First Councilor District, to serve for five years, to succeed A. Reynolds Crane, M.D., Philadelphia County, who is eligible for reelection, having served one term of five years.

A Trustee and Councilor for the Sixth Councilor District, to serve for five years, to succeed H. Thompson Dale, M.D., Centre County, who is eligible for reelection, having served one term of five years.

A Trustee and Councilor for the Eighth Councilor District, to serve for two years, to complete the unexpired term of James A. Biggins, M. D., Mercer County, who has submitted his resignation effective at the close of the 1969 Annual Session.

Also to be elected for a two-year term beginning January 1, 1970, will be *six delegates and six alternate delegates to the American Medical Association.*

Delegates whose terms expire December 31, 1969 are:
Wendell B. Gordon, M.D., Allegheny County
Samuel B. Hadden, M.D., Philadelphia County
Edward Lyon, Jr., M.D., Lycoming County
Thomas W. McCreary, Sr., M.D., Beaver County
Russell B. Roth, M.D., Erie County

The last vacancy for the position of delegate has occurred as a result of the passing of W. Benson Harer, M.D., Delaware County.

Alternates whose terms expire December 31, 1969 are:
Wilbur E. Flannery, M.D., Lawrence County
Paul S. Friedman, M.D., Philadelphia County
John F. Hartman, Jr., M.D., Erie County
Carl B. Lechner, M.D., Erie County
Matthew Marshall, Jr., M.D., Allegheny County
David S. Masland, M.D., Cumberland County

Also to be elected will be *a member to serve for three years on the Committee to Nominate Delegates and Alternates to the American Medical Association* to succeed John B. Montgomery, M.D., Philadelphia County, whose term expires and who is eligible to succeed himself.

Also to be elected will be *one member of the Judicial Council* to serve for a term of five years to succeed William F. Brennan, M.D., Allegheny County, who is eligible for reelection after serving two years of the unexpired term of Theodore R. Fetter, M.D., Philadelphia County, deceased.

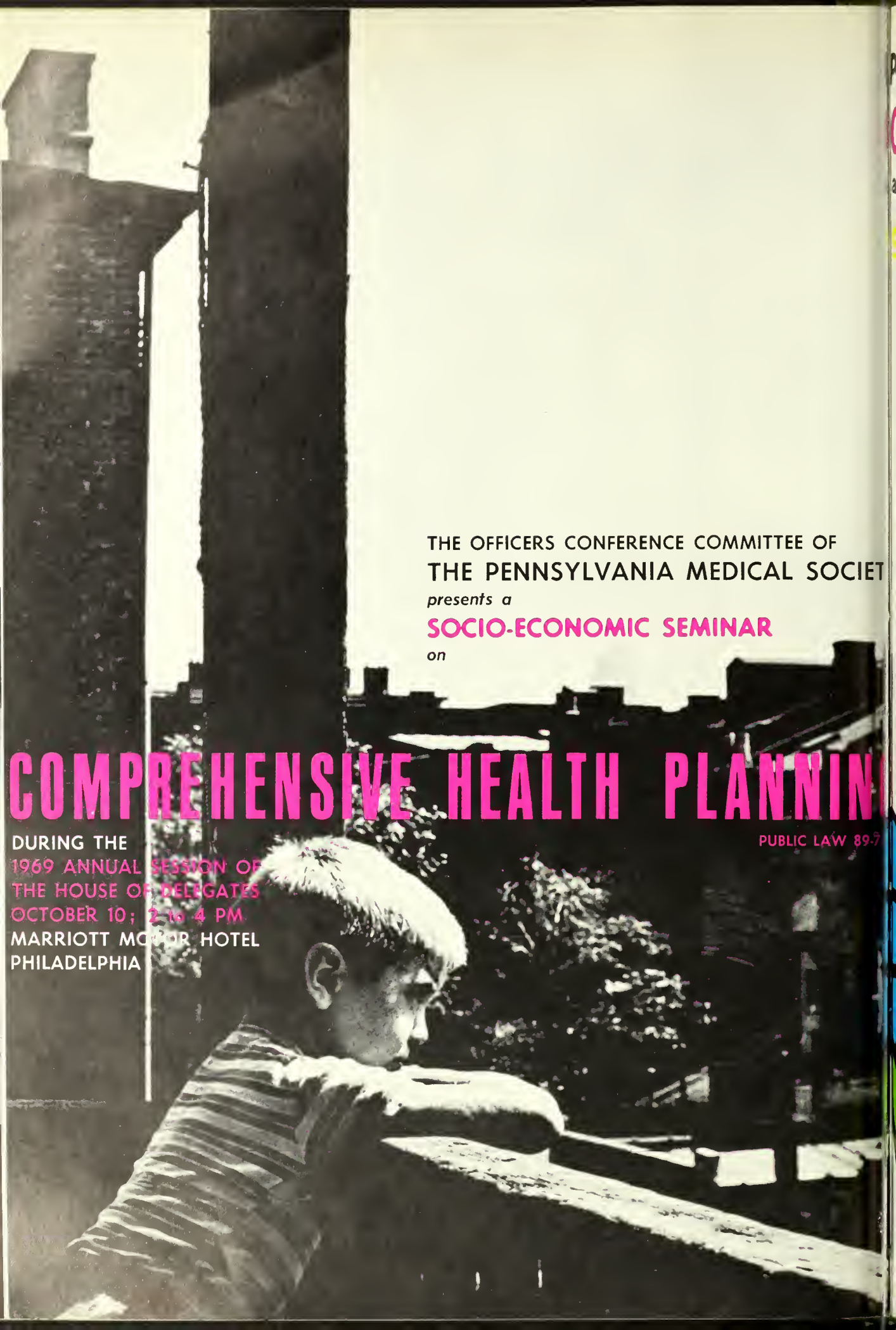
The Constitution provides that the Board of Trustees and Councilors shall nominate at least three qualified members to fill the vacancy on the Judicial Council. Accordingly the Board of Trustees has submitted the following names in nomination for this vacancy: William F. Brennan, M.D., Allegheny County; Allen W. Cowley, M.D., Dauphin County; and Ernest P. Gigliotti, M.D., Jefferson County. Nominations may also be made from the floor of the House of Delegates.

Also to be elected is *a District Censor from each component county medical society* to serve for one year following the close of the 1969 House of Delegates' session.

The component county medical societies have submitted the following nominations for District Censor: *Adams,* James H. Allison; *Allegheny,* Robert A. Schein; *Armstrong,* Arthur R. Wilson; *Beaver,* Herman Bush; *Bedford,* Graffious L. Rinard; *Berks,* Ethan L. Trexler, *Blair,* John W. Hurst; *Bradford,* Willis Redding; *Bucks,* Stanley F. Peters; *Butler,* William R. Fitzsimmons; *Cambria,* Warren F. White; *Carbon,* James M. Steele; *Centre,* H. Richard Ishler; *Chester,* Irving M. Waggoner; *Clarion,* Theodore R. Koenig; *Clearfield,* Fred Pease; *Clinton,* John P. Brandt; *Columbia,* G. Paul Moser; *Crawford,* David D. Kirkpatrick, Jr.; *Cumberland,* Hans S. Roe; *Dauphin,* Hamblen C. Eaton; *Delaware,* Edward G. Torrance; *Elk-Cameron,* James L. Hackett, Sr.; *Erie,* Joseph M. Faso; *Fayette,* Othello S. Kough; *Franklin,* Albert W. Freeman; *Greene,* William W. Bartholomew; *Huntingdon,* Frederic H. Steele; *Indiana,* Robert G. Goldstrohm; *Jefferson,* Franklin S. Bizousky; *Lackawanna,* John C. Sanner; *Lancaster,* William A. Atlee; *Lawrence,* Gerald H. Weiner; *Lebanon,* C. Ray Bell, Jr.; *Lehigh,* Frederick R. Bausch, Jr.; *Luzerne,* Donald F. Closterman; *Lycoming,* Wilfred W. Wilcox; *McKean,* Ralph E. Hockenberry; *Mercer,* Robert W. Monroe; *Mifflin-Juniata,* John R. W. Hunter, Jr.; *Monroe,* Claus G. Jordan; *Montgomery,* Rudolph K. Glocker; *Montour,* Isaac L. Messmore; *Northampton,* Walter J. Filipek; *Northumberland,* J. Mostyn Davis, Jr.; *Perry,* William Magill; *Philadelphia,* Charles M. Thompson; *Potter,* Herman C. Mosch; *Schuylkill,* Joseph T. Marconis; *Somerset,* Alexander Solosko; *Susquehanna,* Raymond C. Davis; *Tioga,* James W. Montague; *Union,* John S. Purnell, Sr.; *Venango,* Roland H. Corbet; *Warren,* Robert D. Donaldson; *Washington,* Herbert J. Levin; *Wayne-Pike,* Hobart N. Owens; *Westmoreland,* Leslie S. Pierce; *Wyoming,* John S. Rinehimer, Jr.; *York,* William C. Langston.

This Call to the Annual Session of the House of Delegates has been issued this 1st day of July, 1969.

Allen W. Cowley, M. D.
Secretary



THE OFFICERS CONFERENCE COMMITTEE OF
THE PENNSYLVANIA MEDICAL SOCIET
presents a
SOCIO-ECONOMIC SEMINAR
on

COMPREHENSIVE HEALTH PLANNIN

PUBLIC LAW 89-7

DURING THE
1969 ANNUAL SESSION OF
THE HOUSE OF DELEGATES
OCTOBER 10; 2 to 4 PM
MARRIOTT MOTOR HOTEL
PHILADELPHIA

PENNSYLVANIA MEDICAL SOCIETY

CLINICAL THERAPEUTICS–1969

at the Host Farm Resort Motel, Lancaster, Pennsylvania

SEPTEMBER 15, 16, 17, 18 - 1969

–PROGRAM–

SEPT. 15

ANTIBIOTICS, BACTERIA AND THE HOST

9:00 a.m. to 12:30 p.m. — PMS SEMINAR

Session Chairman:

JEROME CHAMOVITZ, M.D., Member, Council on Education and Science

* **9:00 a.m.** How Antibiotics Work: New Concepts

JACK L. STROMINGER, M.D., Harvard Medical School, Boston, Mass.

* **9:30 a.m.** Selection of an Antibiotic: Clinical vs. Laboratory Judgment

HARRY F. DOWLING, M.D., Professor and Head, Department of Medicine, University of Illinois College of Medicine, Chicago, Ill.

***10:15 a.m.** Use of the Laboratory in Evaluating Developing Resistance

EDWARD W. HOOK, M.D., Professor and Chairman, Department of Medicine, University of Virginia School of Medicine, Charlottesville, Va.

***10:45 a.m.** Host Factors: The Patient's Contribution to the Battle

LOUIS WEINSTEIN, M.D., Chief, Infectious Disease Service, New England Center Hospital, Boston, Mass.

11:15 a.m. Panel: Clinical Management Problems

Moderator:

ROBERT AUSTRIAN, M.D., Professor and Chairman, Department of Research Medicine, Hospital of the University of Pennsylvania, Philadelphia

Participants:

JACK L. STROMINGER, M.D.
HARRY F. DOWLING, M.D.
EDWARD W. HOOK, M.D.
LOUIS WEINSTEIN, M.D.

* A 10-minute question and answer period will follow each presentation.

2:00 p.m. to 5:00 p.m. — SPECIALTY SEMINARS

PA. SOCIETY OF INTERNAL MEDICINE and AMERICAN COLLEGE OF PHYSICIANS

Session Chairman:

JAMES A. COLLINS, JR., M.D., Danville, President, Pa. Society of Internal Medicine

2:00 p.m. Treatment of Bacterial Meningitis

JOSEPH F. RODGERS, M.D., Instructor, Internal Medicine, Jefferson Medical College of Philadelphia

2:35 p.m. Drug Therapy of Urinary Tract Infection

ARTHUR C. WHITE, M.D., Professor of Medicine, Indiana University School of Medicine, Indianapolis, Ind.

3:20 p.m. Therapy of Bacterial Endocarditis

ROBERT S. PRESSMAN, M.D., Assistant Professor of Medicine, Temple University School of Medicine, Philadelphia

3:55 p.m. Therapy of Pneumoccal Pneumonia

ROBERT C. AUSTRIAN, M.D., Professor and Chairman, Department of Research Medicine, Hospital of the University of Pennsylvania, Philadelphia

4:30 p.m. Choice of an Antibiotic—Old or New?

EDWARD L. QUINN, M.D., Division of Infectious Diseases, Henry Ford Hospital, Detroit, Mich.

Note: A five-minute discussion period will follow each presentation.

2:00 p.m. to 4:30 p.m.

AMERICAN COLLEGE OF CHEST PHYSICIANS PENNSYLVANIA THORACIC SOCIETY and THE LAENNEC SOCIETY

PANEL: PULMONARY EMBOLISM-RECOGNITION AND TREATMENT

Moderator:

EUGENE D. ROBIN, M.D., Professor of Medicine, University of Pittsburgh School of Medicine

Participants:

FRANK D. GRAY, JR., M.D., Professor of Medicine, Jefferson Medical College of Philadelphia

ALBERT H. NIDEN, M.D., Professor of Medicine and Chief of Pulmonary Disease Section, Temple University School of Medicine, Philadelphia

SOL SHERRY, M.D., Professor and Chairman, Department of Medicine, Temple University School of Medicine, Philadelphia

JAMES K. ALEXANDER, M.D., Professor of Medicine, Baylor University College of Medicine, Houston, Tex.

PENNSYLVANIA ALLERGY ASSOCIATION

THE CLINICAL RELIEF OF THE ASTHMATIC ATTACK

Session Chairman:

MACY I. LEVINE, M.D., Pittsburgh, President-Elect, Pa. Allergy Association

Short Case Reports On:

The Initial Attack—Wheezing and Dyspnea

2:00 p.m. The Use of Catecholamines

HAROLD I. LECKS, M.D., Associate Professor of Clinical Pediatrics, University of Pennsylvania School of Medicine, Philadelphia

The Prolonged Attack—Wheezing Continues

2:15 p.m. The Use of Aminophylline

DAVID LEE MILLER, M.D., Research Fellow, Clinical Immunology and Pediatric Allergy, Jefferson Medical College of Philadelphia

The Unresponsive Patient

2:30 p.m. The Use of Buffers

STANLEY C. USHINSKI, M.D., Assistant Professor of Pharmacology and Pediatrics, University of Pittsburgh School of Medicine

2:45 p.m. The Need for Corticosteroids

LOUIS TUFT, M.D., Emeritus Clinical Professor of Medicine, Temple University School of Medicine, Philadelphia

3:00 p.m. The Need for Controlled Ventilation

HERBERT C. MANSMANN, JR., M.D., Professor of Pediatrics and Associate Professor of Medicine, Jefferson Medical College of Philadelphia

The Recurrent Attack

3:15 p.m. Their Control with Oral Medication

MACY I. LEVINE, M.D., Clinical Assistant Professor of Medicine, University of Pittsburgh School of Medicine

A Look in the Future

3:30 p.m. Chemical Mediator Blocking Agents

IRVING H. ITKIN, M.D., Professor of Medicine, Hahnemann Medical College and Hospital Philadelphia

3:45 p.m. Panel Discussion

Moderator:

HERBERT C. MANSMANN, JR., M.D.

Participants:

HAROLD I. LECKS, M.D.

DAVID LEE MILLER, M.D.

STANLEY C. USHINSKI, M.D.

LOUIS TUFT, M.D.

MACY I. LEVINE, M.D.

IRVING H. ITKIN, M.D.

2:00 p.m. to 4:30 p.m.

PA. ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION

PHILADELPHIA RHEUMATISM SOCIETY and PENNSYLVANIA ARTHRITIS FOUNDATIONS

THE CONSERVATIVE MANAGEMENT OF RHEUMATOID ARTHRITIS

Moderator:

JOSEPH L. HOLLANDER, M.D., Professor of Medicine, University of Pensylvania School of Medicine, Philadelphia

Basic Management—salicylates, rest, exercise, nutrition and incidence of Rheumatoid Arthritis

EDWARD E. FISCHEL, M.D., Associate Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons, New York, N. Y.

Acetylsalicylic Acid

KENNETH FREEMONT-SMITH, M.D., Instructor of Medicine, Harvard Medical School, Boston, Mass.

Rest and Exercise

EMERY K. STONER, M.D., Associate Professor and Clinical Director, Department of Physical Medicine and Rehabilitation, University of Pennsylvania Hospital, Philadelphia

2:00 p.m. to 4:30 p.m.

PA. CHAPTER of the AMERICAN ACADEMY OF PEDIATRICS

Moderator:

WILLIAM N. MEBANE III, M.D., Associate Attending Pediatrician, St. Christopher's Hospital for Children, Philadelphia

2:00 p.m. The Mis-Use of Anti-microbial Agents in Pediatrics

SIDNEY SUSSMAN, M.D., Director, Pediatric Out-Patient Department, St. Christopher's Hospital for Children, Philadelphia

2:30 p.m. Some Recent Advances in the Diagnosis, Prevention and Treatment of Viral Illnesses in Children

ADAMADIA DeFOREST, Ph.D., Virologist, St. Christopher's Hospital for Children, Philadelphia

(3:00 p.m. to 3:30 p.m.—Intermission to View Exhibits)

3:30 p.m. The Therapeutic Approach to Common Pediatric Infections

JOSEPH M. GARFUNKEL, M.D., Director, Division of Pediatrics, Harrisburg Polyclinic Hospital

9:00 p.m. to 10:30 p.m. — EVENING PROGRAM

THE ROLE OF PMS IN EDUCATION

Set up will be tables for 10—with a member of the Council on Education and Science serving as discussion leader at each table. Four questions will be discussed at each table.

Suggested questions:

1. Who Should Program Reach?
2. What Type Program is Needed?
   a. Format
   b. Locale
3. Motivation for Self-Improvement (Life-time Learning)
4. How Can Medical Audits Improve Patient Care?

HORMONES—THE MIRACLE HAS A PRICE

9:00 a.m. to 12:30 p.m. — PMS SEMINAR

Session Chairman:

JOHN H. MOYER, III, M.D., Member, Council on Education and Science

* **9:00 a.m.** Hormonal Influences: Clinical Problems in Fluid & Mineral Metabolism

T. S. DANOWSKI, M.D., Professor of Medicine, University of Pittsburgh School of Medicine

* **9:30 a.m.** Hormonal Influences on Carbohydrate Metabolism

RICHARD A. FIELD, M.D., Professor of Medicine; Director, Division of Endocrinology and Metabolic Diseases, Jefferson Medical College of Philadelphia

***10:15 a.m.** The Pill—Does It Do More Than Bargained For?

CELSO-RAMON GARCIA, M.D., Professor, Department of Obstetrics and Gynecology, University of Pennsylvania School of Medicine, Philadelphia

***10:45 a.m.** Non-Endocrine Uses of Endocrine Substances

JOSEPH J. RUPP, M.D., Associate Professor of Medicine, Jefferson Medical College of Philadelphia

11:15 a.m. Panel: Despite the Price, When Do You Use Them?

Moderator:

T. S. DANOWSKI, M.D.

Participants:

RICHARD A. FIELD, M.D.

CELSO-RAMON GARCIA, M.D.

JOSEPH J. RUPP, M.D.

* A 10-minute question and answer period will follow each presentation.

AMERICAN COLLEGE OF PHYSICIANS and PA. SOCIETY OF INTERNAL MEDICINE

Session Chairman:

WILLIAM M. COOPER, M.D., Pittsburgh Governor for Western Pennsylvania, American College of Physicians

2:00 p.m. Steroid Therapy of Ulcerative Colitis and Crohn's Disease

LAWRENCE M. MLECKO, M.D., Associate Attending Physician, Department of Gastroenterology, Allegheny General Hospital, Pittsburgh

2:35 p.m. Treatment of Hyperthyroidism (including pregnancy) and Expected Results, Near Term and Long Term

NORMAN G. SCHNEEBERG, M.D., Clinical Professor of Medicine, Hahnemann Medical College and Hospital, Philadelphia

3:20 p.m. Treatment of Hypothyroid States, Cretinism, Myxedema, Misuse of Thyroid Hormone

WAYNE V. GREENBERG, M.D., Allegheny General Hospital, Pittsburgh

3:55 p.m. Endocrine Treatment of Menstrual Disorders, Fertility and Infertility

ALVIN F. GOLDFARB, M.D., Assistant Professor, Obstetrics & Gynecology, Jefferson Medical College of Philadelphia

Note: A five-minute discussion period will follow each presentation.

PENNSYLVANIA PSYCHIATRIC SOCIETY

PSYCHIATRY AND OUR LAWS REGARDING PERVERSION, ABORTION AND DIVORCE

Session Chairman:

ULYSSES E. WATSON, M.D., Medical Director, Friends Hospital, Philadelphia

2:00 p.m. Guest Speaker: ANDREW S. WATSON, M.D., University of Michigan, Ann Arbor

2:40 p.m. Panel:

Moderator:

ROBERT L. SADOFF, M.D., Assistant Professor of Psychiatry, Temple University, Philadelphia

Participants:

JUDGE LEO WEINROTT, Municipal Judge, Philadelphia

MELVIN S. HELLER, M.D., Clinical Professor, Department of Psychiatry, Temple University School of Medicine, Philadelphia

RICHARD G. LONSDORF, M.D., Associate Professor of Psychiatry, University of Pennsylvania, Philadelphia

SAMUEL POLSKY, L.L.B., Ph.D., Professor of Law, Temple University, Philadelphia

PENNSYLVANIA HEART ASSOCIATION PENNSYLVANIA THORACIC SOCIETY AMERICAN COLLEGE OF CHEST PHYSICIANS THE LAENNEC SOCIETY

RECENT DEVELOPMENTS IN THE THERAPY OF CARDIAC AND PULMONARY DISEASES

Session Chairman:

LOUIS SOLOFF, M.D., Professor and Chairman, Department of Cardiology, Temple University School of Medicine, Philadelphia

2:00 p.m. THE CHEVALIER JACKSON MEMORIAL LECTURE:
Immunologic Problem of Heart and Lung Transplants

J. WAYNE STREILEIN, M.D., Assistant Professor, Departments of Medicine and Medical Genetics, University of Pennsylvania School of Medicine, Philadelphia

3:00 p.m. The Use of a Permanently Implanted Transvenous Cardiac Pacemaker

GEORGE J. HAUPT, M.D., Associate Professor of Surgery, Jefferson Medical College of Philadelphia

3:15 p.m. **Comment:**

HOWARD WARNER, M.D., Assistant Professor of Medicine, Temple University School of Medicine, Philadelphia

3:45 p.m. The Value of a Post Acute Myocardial Infarction Exercise Program

JAMES W. DALY, M.D., Assistant Professor, Clinical Medicine, Jefferson Medical College of Philadelphia

4:00 p.m. **Comment:**

LOUIS SOLOFF, M.D.

4:05 p.m. The Treatment of Hyperlipemic States

WILLIAM L. HOLMES, Ph.D., Director of Research, Lankenau Hospital, Philadelphia

4:20 p.m. **Comment:**

LOUIS SOLOFF, M.D.

2:00 p.m. to 4:30 p.m.

PA. ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION

PHILADELPHIA RHEUMATISM SOCIETY and PENNSYLVANIA ARTHRITIS FOUNDATION

REHABILITATION IN RHEUMATOID ARTHRITIS—FACT OR FANCY

(A Critical Survey of the Program)

Moderator:

PAUL J. VIGNOS, JR., M.D., Associate Professor of Medicine, Case Western Reserve University School of Medicine, Cleveland, Ohio

Rheumatologist:

GERALD RODMAN, M.D., Professor of Medicine; Director, Section on Rheumatology, University of Pittsburgh School of Medicine

Orthopedist:

MARK S. KAUFFMAN, M.D., Clinical Instructor, Temple University School of Medicine, Philadelphia

Psychiatrist:

RONALD H. ROSILLO, M.D., Assistant Professor, Physical Medicine and Rehabilitation, University of Pennsylvania School of Medicine, Philadelphia

Physical Medicine and Rehabilitation:

THOMAS C. HOHMANN, M.D., Medical Director, Department of Physical Medicine and Rehabilitation, St. Francis General Hospital, Pittsburgh

2:00 p.m. to 4:30 p.m.

UROLOGICAL ASSOCIATION OF PENNA., INC.

CARCINOMA OF THE PROSTATE: A CRITICAL REAPPRAISAL OF ITS TREATMENT

Remarks:

DAVID M. DAVIS, M.D., Professor Emeritus of Urology, Jefferson Medical College of Philadelphia

Speaker:

JOHN D. YOUNG, M.D., Professor and Chairman, Department of Urology, University of Maryland, Baltimore, Md.

Speaker:

GEORGE R. PROUT, JR., M.D., Professor of Surgery (Urology), Harvard Medical School, Boston, Mass.

AMERICAN CANCER SOCIETY PENNSYLVANIA DIVISION, INC., and PHILADELPHIA DIVISION, INC.

BREAST CANCER 1969

Session Chairman:

SAMUEL P. HARBISON, M.D., Professor of Surgery and Associate Dean, University of Pittsburgh School of Medicine

2:00 p.m. Surgery of Operable Breast Cancer

GEORGE P. ROSEMOND, M.D., Professor and Chairman, Department of Surgery, Temple University Health Sciences Center, School of Medicine, Philadelphia

2:20 p.m. Ablative Surgery for Disseminated Breast Cancer

B. J. KENNEDY, M.D., Professor of Medicine, University of Minnesota Medical School, Minneapolis, Minn.

2:40 p.m. Radiation Therapy for Breast Cancer

RUTH J. GUTTMANN, M.D., Professor of Radiology and Director, Department of Radiation Therapy, Francis Delafield Hospital, New York, N.Y.

3:00 p.m. Hormones in Breast Cancer Therapy

HARRY F. BISEL, M.D., Head, Section of Clinical Oncology, Mayo Clinic, Rochester, Minn.

3:20 p.m. Office Chemotherapy for Breast Cancer

ROBERT GLENN RAVDIN, M.D., Professor of Surgery, University of Pennsylvania Medical School, Philadelphia

3:40 p.m. Rehabilitation of the Mastectomy Patient

JOSEPH NOVAK, M.D., Director of Physical Medicine and Rehabilitation, Mercy Hospital, Pittsburgh

4:00 p.m. Panel Discussion

Moderator:

SAMUEL P. HARBISON, M.D.
(All previous speakers will participate)

SEPT. 17

ADMINISTERING TO THE ACHING AND JITTERY HEART

9:00 a.m. to 12:30 p.m. — PMS SEMINAR

Session Chairman:

ROBERT L. EVANS, M.D., Member, Council on Education and Science

* **9:00 a.m.** Coronary Vasodilators: The Fact

HENRY ZIMMERMAN, M.D., Director, Marie L. Coakley Cardiovascular Laboratory, St. Vincent Charity Hospital, Cleveland, Ohio

* **9:30 a.m.** Coronary Vasodilators: The Fiction

BERNARD L. SEGAL, M.D., Clinical Associate Professor of Medicine, Hahnemann Medical College and Hospital, Philadelphia

***10:00 a.m.** Regulating Some of the Irregularities

WARREN P. GOLDBURGH, M.D., Assistant Professor of Clinical Medicine; Director of Cardiac Clinic, Jefferson Medical College Hospital, Philadelphia

***10:45 a.m.** Pharmacologic Approach to Cardiogenic Shock

ROBERT H. PETER, M.D., Assistant Professor of Medicine, Divison of Cardiology, Duke University Medical Center, Durham, N.C.

11:15 a.m. Panel: Illustrated with Case Presentations
(cases distributed to audience and panelists)

Moderator:

ROBERT L. EVANS, M.D., Vice President, Medical Affairs, York Hospital, York

Participants:

HENRY ZIMMERMAN, M.D.
BERNARD L. SEGAL, M.D.
WARREN P. GOLDBURGH, M.D.
ROBERT H. PETERS, M.D.
JOHN H. KILLOUGH, Ph.D., M.D.

* A 10-minute question and answer period will follow each presentation.

2:00 p.m. to 5:00 p.m. — SPECIALTY SEMINARS

PA. SOCIETY OF COLON & RECTAL SURGERY

Presiding:

JOSEPH B. SARNER, M.D., Philadelphia, President, Pa. Society of Colon and Rectal Surgery

2:00 p.m. Management of Anorectal Abscesses and Fistulae

J. EDWIN ALFORD, M.D., Clinical Professor of Surgery (Proctology), University of Buffalo, Buffalo

2:40 p.m. Large Bowel Anastomosis—One Layer Suture Technic

HOWARD D. TRIMPI, M.D., Senior Attending Surgeon, Allentown Hospital, Allentown

2:50 p.m. Large Bowel Anastomosis—One or Two Layer Suture Technic?

ANDREW JACK McADAMS, M.D., Chief, Division of Colon and Rectal Surgery, Western Pennsylvania Hospital, Pittsburgh

3:00 p.m. Office Ligature Treatment of Internal Hemorrhoids

EUGENE P. SALVATI M.D., Plainfield, N.J.

3:10 p.m. When to Inject Hemorrhoids and How to Do It

SAMUEL W. EISENBERG, M.D., Clinical Professor of Surgery (Proctology), Temple University Medical Center, Philadelphia

3:20 p.m. How to Avoid Skin Tags and Diminish Pain Following Hemorrhoidectomy

A. GERSON CARMEL, M.D., Assistant Clinical Professor of Surgery, University of Cincinnati College of Medicine, Cincinnati, Ohio

3:30 p.m. Questions and Answers

3:40 p.m. Management of Patients with Recurrent Rectal Cancer

Panel Moderator:

HARRY E. BACON, M.D., Professor of Surgery (Proctology) Temple University Medical Center, Philadelphia

Participants:

PETER V. MARTIN, M.D., Senior Attending Surgeon, Allentown Hospital, Allentown

MILLARD N. CROLL, M.D., Associate Professor of Radiology (Nuclear Medicine), Hahnemann Medical College and Hospital, Philadelphia

CHARLES J. LUSCH, M.D., Chemotherapist, Reading Hospital, Reading

MICHAEL SCOTT, M.D., Professor and Chairman, Department of Neurosurgery, Temple University Medical Center, Philadelphia

FRANCO M. NICHINI, M.D., Associate Professor of Radiology (Radiotherapy), Temple University Medical Center, Philadelphia

4:30 p.m. Questions and Answers

EXHIBITS

Pharmaceutical
Medical & Surgical Equipment
Business Systems
Educational Systems
Insurances
Clothing

PA. ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

SYMPOSIUM: PERSONAL PREFERENCES IN CLINICAL THERAPY

Presiding Officer:

H. FORD CLARK, M.D., Huntingdon, President, Pa. Academy of Ophthalmology and Otolaryngology

2:00 p.m. Ophthalmology:

Moderator:

PAUL H. RIPPLE, M.D., Chief, Department of Ophthalmology, Lancaster General Hospital, Lancaster

Participants:

3:15 p.m. Otolaryngology:
Moderator:

DAVID A. COPE, M.D., Reading

Participants:

EMIL P. LIEBMAN, M.D. Assistant Instructor, Otolaryngology, Temple University Health Sciences Center, Philadelphia

W. VERNON HOSTELLEY, M.D., Associate Professor, Otolaryngology, Hahnemann Medical College and Hospital, Philadelphia

SEBASTIAN ARENA, M.D., Assistant Clinical Professor of Otolaryngology, University of Pittsburgh School of Medicine

KENNETH T. RICHARDSON, M.D., Professor and Chairman, Department of Ophthalmology, University of Pittsburgh School of Medicine

WILLIAM P. BURNS, M.D., Assistant Professor of Ophthalmology, University of Pennsylvania School of Medicine, Philadelphia

EDWARD A. JAEGER, M.D., Assistant Professor of Ophthalmology, Jefferson Medical College of Philadelphia

SEPT. 18

SPECIAL PROBLEMS OF DRUG USAGE

9:00 a.m. to 12:30 p.m. — PMS SEMINAR

Session Chairman:

JOHN H. KILLOUGH, Ph.D., M.D., Chairman, Advisory Committee on Scientific Session; Member, Council on Education and Science

* **9:00 a.m.** Interference of Drugs with Laboratory Tests

F. WILLIAM SUNDERMAN, JR., M.D., Professor and Head, Department of Laboratory Medicine, University of Connecticut School of Medicine, Hartford, Conn.

* **9:40 a.m.** Drug Interactions: How they Interfere with One Another

JOSEPH R. DiPALMA, M.D., Dean and Professor of Pharmacology, Hahnemann Medical College and Hospital, Philadelphia

***10:35 a.m.** Patient Reactions to Drugs: How to Manage

ROBERT H. McDONALD, JR., M.D., Assistant Professor of Pharmacology and Medicine, University of Pittsburgh School of Medicine

11:15 a.m. Panel: Drug Problems and Public Concern

Moderator:

JOSEPH R. DiPALMA, M.D.

Participants:

F. WILLIAM SUNDERMAN, JR., M.D.

ROBERT H. McDONALD, M.D.

* A 10-minute question and answer period will follow each presentation.

2:00 p.m. to 5:00 p.m. — SPECIALTY SEMINARS AND MEETINGS

PA. SOCIETY OF ANESTHESIOLOGISTS
AMERICAN COLLEGE OF CHEST PHYSICIANS
PENNSYLVANIA THORACIC SOCIETY
AMERICAN COLLEGE OF PHYSICIANS
THE LAENNEC SOCIETY

THE MANAGEMENT OF VENTILATORY DISORDERS

Session Chairman:

LEONARD BACHMAN, M.D., Professor of Anesthesiology, University of Pennsylvania School of Medicine, Philadelphia

2:00 p.m. Honorary Lectureship Sponsored by Pa. Society of Anesthesiologists—Respiratory Failure

HENRIK H. BENDIXEN, M.D., Professor of Anesthesia, University of California, San Diego

3:00 p.m. The Treatment of Extensive Chest Wall Trauma

JOSEPH C. DONNELLY, JR., M.D., Instructor in Surgery, Jefferson Medical College of Philadelphia

ACUTE VENTILATORY INSUFFICIENCY

3:45 p.m. The Aggressive Approach

THEODORE RODMAN, M.D., Associate Professor of Medicine, Temple University School of Medicine, Philadelphia

4:00 p.m. The Conservative Approach

PHILIP KIMBEL, M.D., Associate Professor of Medicine, Temple University School of Medicine, Philadelphia

4:15 p.m. The Special Problems of the Infant and Child in Ventilatory Insufficiency

JOHN J. DOWNES, M.D., Assistant Professor, Anesthesia and Pediatrics, University of Pennsylvania School of Medicine, Philadelphia

4:30 p.m. The Role of the Anesthesiologist in an Intensive Respiratory Care Program

SEYMOUR SCHOTZ, M.D., Clinical Associate Professor of Anesthesiology, University of Pennsylvania School of Medicine, Philadelphia

4:45 p.m. The Choice of Antibiotics in the Treatment of Bronchopulmonary Infection in Patients in Ventilatory Failure Secondary to Chronic Obstructive Pulmonary Disease

MICHAEL A. MANKO, M.D., Associate in Medicine, Jefferson Medical College of Philadelphia

PENNSYLVANIA ACADEMY OF DERMATOLOGY

MANAGEMENT OF CUTANEOUS NEOPLASMS

Session Chairman:

CARROLL F. BURGOON, JR., M.D., Professor of Dermatology, Skin and Cancer Hospital, Temple University Health Sciences Center, Philadelphia

2:00 p.m. Chemotherapeutic Agents—Pharmacology and Effects on Proliferating Tumor Cell Systems

JEROME B. BLOCK, M.D., Chief, National Cancer Institute, Baltimore Cancer Research Center, Baltimore, Md.

2:45 p.m. Mycosis Fungoides—Recent Advances

WILLIAM K. STERN, M.D., Instructor in Dermatology, Skin & Cancer Hospital, Temple University Health Sciences Center, Philadelphia

3:10 p.m. Use of Topical Nitrogen Mustard in the Treatment of Mycosis Fungoides

FREDERICK URBACH, M.D., Professor and Chairman, Department of Dermatology, Skin and Cancer Hospital, Temple University Health Sciences Center, Philadelphia

3:50 p.m. Zinc Chloride Treatment of Basal Cell Epithelioma — Why, When, How?

NICHOLAS GIMBEL, M.D., Associate Professor of Surgery, Department of Surgery, University of Pennsylvania School of Medicine, Philadelphia

4:15 p.m. Discussion

SEMINAR FOR NURSES & ALLIED PROFESSIONS — SEPTEMBER 16

Morning Session:

Session Chairman:

JEROME CHAMOVITZ, M.D., Member, Council on Education and Science

9:00 a.m. Antibiotics, Bacteria and the Host

ROBERT S. PRESSMAN, M.D., Assistant Professor of Medicine, Temple University School of Medicine, Philadelphia

9:30 a.m. Questions and Answers

10:00 a.m. The Medical Attendant as a Vector in Infections

JOSEPH M. GARFUNKEL, M.D., Director, Division of Pediatrics, Harrisburg Polyclinic Hospital

10:30 a.m. Questions and Answers

10:45 a.m. "And Sarah Begat Isaac at Age 90"—or—Estrogens Forever

ALVIN F. GOLDFARB, M.D., Assistant Professor of Obstetrics and Gynecology, Jefferson Medical College of Philadelphia

11:15 a.m. Questions and Answers

Afternoon Session:

Session Chairman:

JOHN H. KILLOUGH, Ph.D., M.D., Member, Council on Education and Science

1:00 p.m. Impending Diabetic Emergency: How to Recognize

RICHARD A. FIELD, M.D., Professor of Medicine, Jefferson Medical College of Philadelphia

1:30 p.m. Questions and Answers

1:40 p.m. Management of the Patient with Ventilatory Insufficiency

PHILIP KIMBEL, M.D., Pulmonary Disease Section, Albert Einstein Medical Center, Philadelphia

2:10 p.m. Questions and Answers

2:30 p.m. Bedside Recognition of Cardiac Arrhythmias

WARREN P. GOLDBURGH, M.D., Assistant Professor of Clinical Medicine, Jefferson Medical College of Philadelphia

3:05 p.m. Questions and Answers

3:15 p.m. Is the Pill Better or Bitter?

CELSO-RAMON GARCIA, M.D., Professor of Obstetrics and Gynecology, University of Pennsylvania School of Medicine, Philadelphia

3:45 p.m. Questions and Answers

SPECIAL MEETINGS

Allergy Association
Board of Regents' Meeting—Monday, 12 noon

Colon & Rectal Surgery Society
Luncheon—Wednesday, 12 noon

Dermatological Academy
Business Meeting—Thursday, 4:00 p.m.

Internal Medicine Society
Council Meeting—Monday, 5 p.m.

Medicine & Religion
Workshop (Eastern Pa. chrm.)—Thursday, 9 a.m.

Physical Medicine & Rehabilitation Academy
Business Meeting—Monday, 4:30 p.m.
Banquet—Monday, 7:00 p.m.
Board Meeting—Monday, 12 noon
Business Meeting—Tuesday, 4:30 p.m.

Psychiatric Society
Council Meeting—Monday, 8:00 p.m.
Business Meeting—Tuesday, 9:00 a.m.

Susquehanna Valley RMP
R.A.G. Executive Committee—Thursday, 12 noon

Urological Association
Banquet—Tuesday, 6:00 p.m.

FEES: (to cover coffee and refreshments)

One general fee for registration whether you plan to attend for part of one day or for entire four days.

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Rush Award to Mother of Local Woman

Volunteer, Sisterhood Unit Get Benjamin Rush Awards

Medicol Society Honors Nurse

Medical Society Gives Rush Awards

Emotional Factors in Cardiovascular Disease

Part II

William G. Leaman, Jr., M.D. questions Abraham J. Twerski, M.D, clinical director, department of psychiatry, St. Francis General Hospital, Pittsburgh, Pennsylvania.

In what ways can anxiety be diminished in patients with fresh infarctions?

The patient suffering from a fresh infarct is vulnerable to the lethal effects of anxiety. The irritable myocardium may develop dangerous arrhythmias in response to adrenalin, and endogenous adrenalin is released in anxiety. Certainly, nothing should be done to *increase* the patient's anxiety. Yet, the very atmosphere of the coronary care unit threatens to undo some of its benefits. Therefore, the unit lay-out and the personnel should be very carefully chosen.

What can the physician and nursing staff do to reassure the patient?

The acute coronary patient is concerned with imminent death. To tell him that there is nothing seriously wrong with him is less than worthless, since the patient deduces that the atmosphere alone indicates that his condition *is* precarious. Such a futile attempt at reassurance undermines the patient's trust in his doctor. Instead, tell the patient, "We want to keep you under close observation here for one or two days to avoid complications, and then you will be moved to your own room. For the first few days your activity will be restricted, then you'll gradually be allowed to increase it." Let the patient know that the acute coronary care unit indicates to him that you are foreseeing his survival and ultimate recovery, while not unrealistically denying the seriousness of his illness.

What can be done to minimize the post-infarction anxiety in a patient recovering from myocardial infarction?

This is a most delicate area, since it places the physician within a very narrow latitude wherein he must exert just the optimum amount of caution and observation, without inducing *undue* concern about the heart. For example, frequent electrocardiograms may be interpreted by the patient as an indication of progressive disease, and the physician should avail himself of just those tests necessary to evaluate the recovery process. After all, tests, like medication, have side-effects that must be considered.

Are ataractic drugs of value in cardiovascular disease?

Tranquilizing drugs certainly have a place in the management of cardiovascular disease. Avoid drugs that have hypotensive effects. Remember that the rauwolfia drugs, while useful as anti-hypertensives, occasionally bring about depressive reactions. Time-proven phenobarbital, in small doses, remains an excellent mild sedative.

Should patients considered to have strong emotional components to their cardiovascular disease be referred to psychiatrists for treatment?

Generally, no. The individual most ideally situated to provide psychotherapy is the physician treating the illness. Consultation with a psychiatrist may be desirable at times, but the main therapy should be carried out by the attending physician.

What is meant by cardiac neurosis?

Cardiac neurosis is a broad term which may be applied to any situation wherein the patient has greater concern and preoccupation with his heart than is warranted by clinical and laboratory evaluation. It generally occurs against a background of anxiety which may be of diverse origin.

Are there specific precipitants in cardiac neurosis?

Yes. Some of the more common are: (1) A statement by a physician that there is an irregular rhythm or a murmur. The patient cannot distinguish an inconsequential finding from a significant one, and may focus on his "heart disease." (2) Occurrence of dramatic heart disease or sudden death in a relative or close friend. (3) Any symptom drawing attention to the heart, e.g., chest pain of extracardiac origin, palpitation and/or an anxiety attack, arrhythmias, etc. (4) An imminent situation which the individual cannot otherwise evade, but wishes (consciously or unconsciously) to evade, e.g., induction into the armed forces, a financial obligation, marriage, divorce, etc.

Are there psychiatric complications resulting from cardiovascular disease?

The person whose usual pace and pattern of life is suddenly restricted may react with depression or he may completely deny his limitations in a hypomanic reaction. Both reactions may be serious, and warrant psychiatric evaluation.

■ **William G. Leaman, Jr., M.D., Fellow, Council on Clinical Cardiology of the American Heart Association, edited this Brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.**

Description: FLUOGEN (Influenza Virus Vaccine, Bivalent, Ether Extracted Antigen) (Types A_2 and B) is composed of the antigen of the strains of influenza viruses recommended by the Division of Biologics Standards, National Institutes of Health, Public Health Service. It is formulated to contain 400 CCA (chick cell agglutination) units of extracted immunizing antigen of type A_2/Aichi/2/68 strain (Hong Kong variant) and 300 CCA units of extracted immunizing antigen of B/Massachusetts/3/66 strain for a total of not less than 700 CCA units per each 0.5 cc. dose. **Method of Preparation:** The influenza viruses are propagated on developing chick embryos. The extra-embryonic fluid containing the virus suspension is harvested, clarified by filtration and concentrated and refined by ultracentrifugation. Polysorbate-80, U.S.P. (175 mcg. per 0.5 cc.) is added to the refined concentrate. The refined concentrate is extracted with ethyl ether, stabilized with formalin, and preserved with 0.01% thimerosal (mercury derivative). The vaccine contains not more than 1:12,000 formalin, used during the process. It does not contain penicillin. Aluminum phosphate, 1.5 mg. per 0.5 ml. is added to the vaccine as an adjuvant. **Indications:** FLUOGEN is indicated for the production of immunity to influenza produced by the strains of virus containing antigens related to those in the vaccine. FLUOGEN is recommended primarily as a seasonal booster for persons who were previously vaccinated with vaccines containing the A_2 Hong Kong variant. It may also be used for primary immunization of those who have not previously received the Hong Kong variant. It is recommended that both primary and booster immunization be completed by early December since influenza is more likely to appear during cold weather. It is understood that should epidemic conditions be predicted, immunization procedures should be initiated regardless of the time of year. Attempts to produce immunity following the appearonce of an epidemic may be less successful because of the rapidity with which the disease spreads and the time required for antibody production following vaccination. The degree of protection afforded by immunization with any vaccine may not be sufficient to prevent the disease if the exposure to the influenza virus strains is overwhelming or if the virus strains are not closely related antigenically to those used in the production of vaccine. Although routine vaccination of healthy groups of adults and children is not recommended, when widespread epidemics of influenza are forecast, vaccination may be considered if above-average levels of absenteeism would disrupt satisfactory operations in industries, schools, and other such groups. **Contraindications:** The use of products prepared from the embryonic fluid of chicken eggs is contraindicated in persons with a history of allergy to eggs, chicken, chicken feothers, or chicken dander. In persons suspected of having an allergic condition, immunization procedures should be preceded by a scratch test or an intradermal injection (0.05 ml. to 0.1 ml.) of vaccine diluted 1:100 in sterile saline to determine possible sensitivity to the minute residual egg protein that may be present in the vaccine. A positive skin reaction contraindicates immunization with the vaccine. Immunization should be deferred in the presence of any acute respiratory disease or other active infection. It should also be deferred in the presence of an epidemic of poliomyelitis unless the risk of influenza represents a greater threat to the patient than the increased possibility of poliomyelitis. **Precautions:** A separate sterile syringe and needle should be used for each patient to prevent transmission of homologous serum hepatitis virus or other infectious agent from one person to another. Reusable glass syringes and needles should be heat sterilized. Epinephrine should be immediately available for use should an acute onaphylactoid reaction occur in individuals having an undisclosed hypersensitivity to any component of the vaccine. Because of the possibility of a febrile reaction following immunization with influenza virus vaccine, the wisdom of attempting to immunize patients with a history of febrile convulsion should be given careful consideration. **Adverse reactions:** Most frequent reaction reported in early clinical studies† with ether-extracted vaccine was tenderness at the site of injection. Headache and malaise were reported in up to about 12% of subjects. Nausea and fever occurred in approximately 5% of the patients. Muscle ache, joint pain, chills, fatigue, and anorexia occurred in less than 5% of the subjects. **Package information:** Bio 579—5 cc. rubber-diaphragm-capped vial. Each 5 cc. vial contains sufficient vaccine to deliver ten 0.5 cc. doses.

†Unpublished data available upon request.

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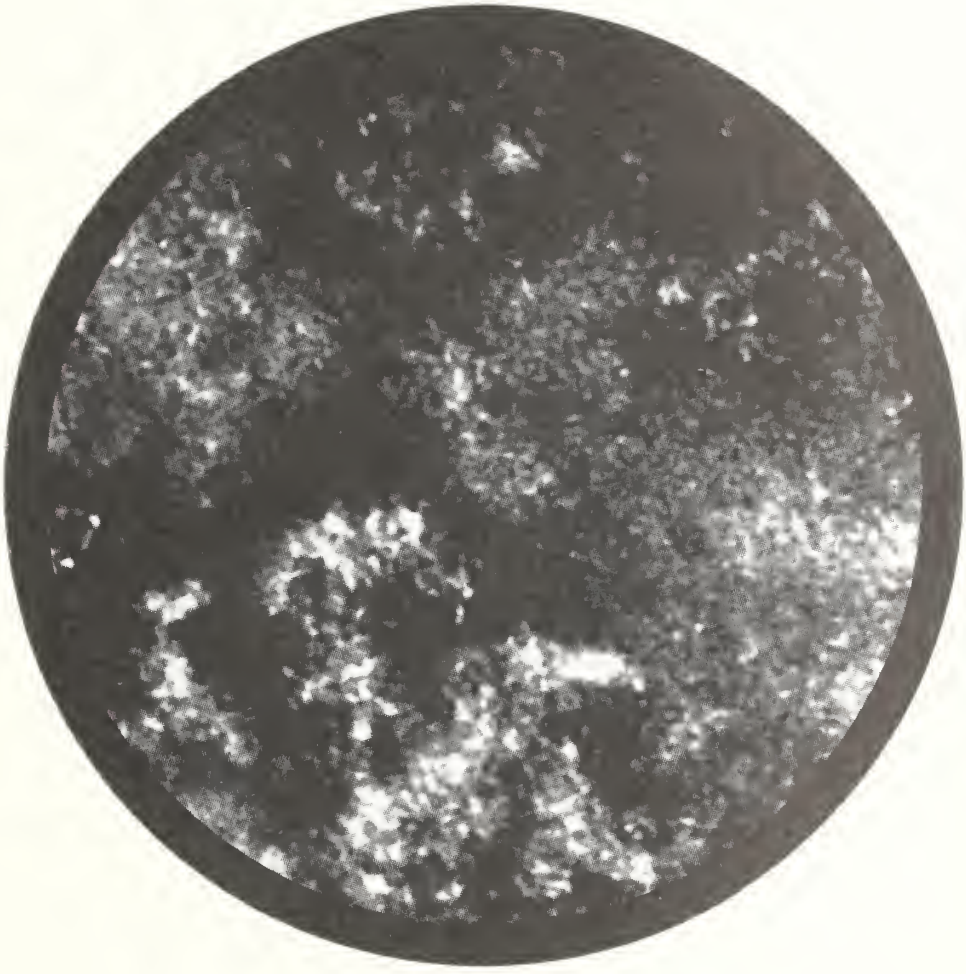

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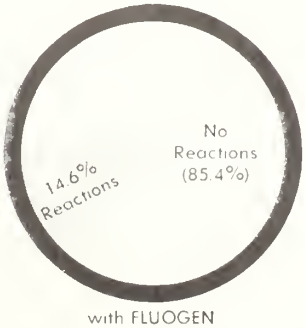

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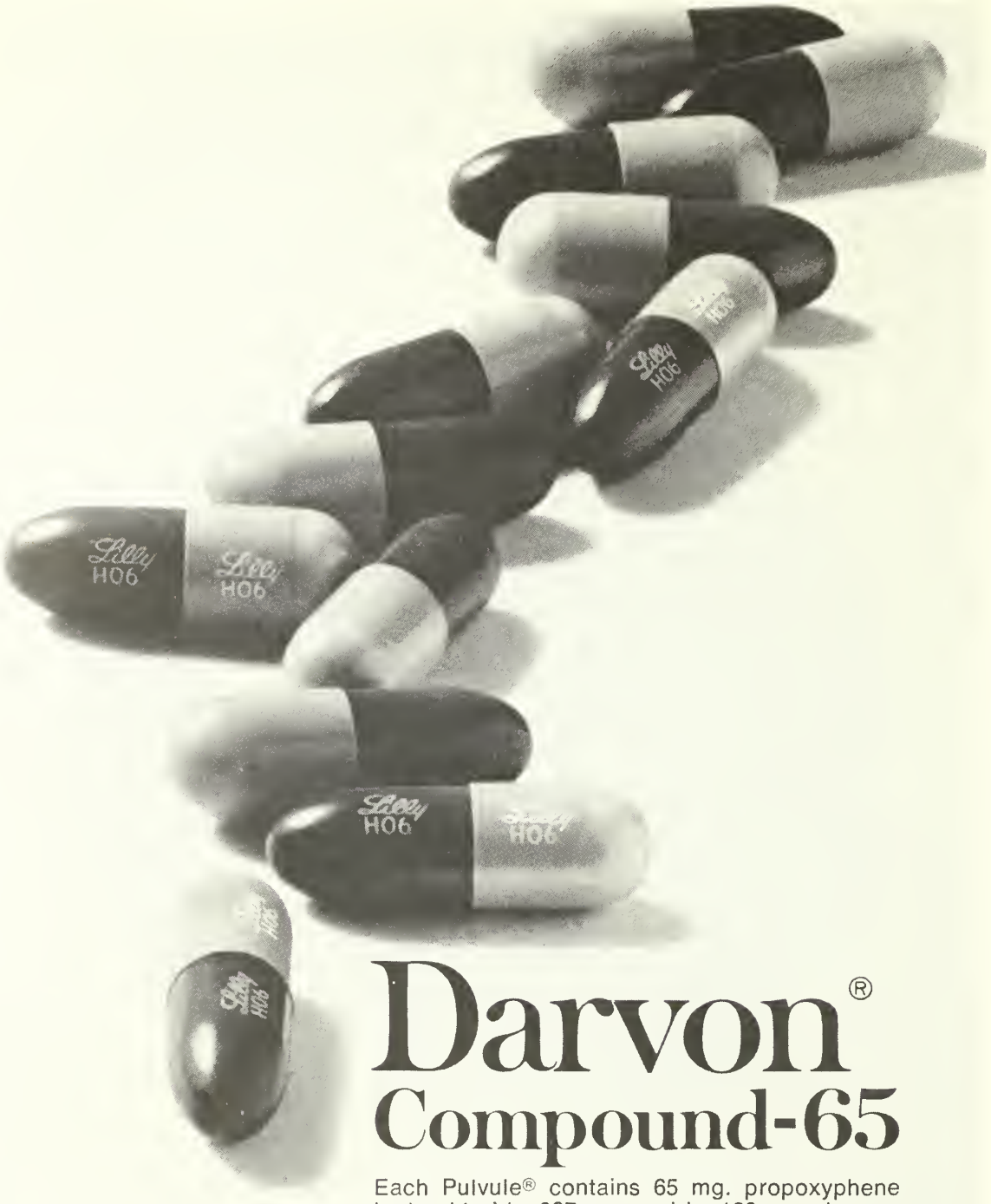
*Summary of results from three studies. References available on request.



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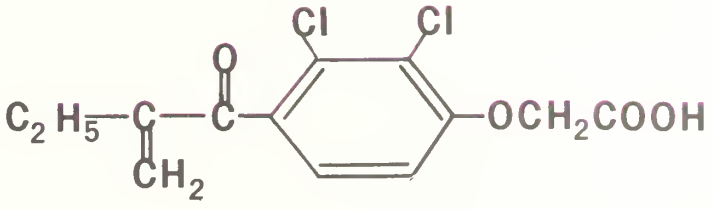

Figure 1. ETHACRYNIC ACID
2, 3-Dichloro-4-(2-Methylenebutyryl) Phenoxy Acetic Acid

Ethacrynic Acid

A Non-Diabetogenic Diuretic

JAMES C. HUTCHISON, M.D.
ABINGTON

Benzothiadiazine (thiazide) diuretics have been shown to provoke or aggravate diabetes mellitus.[1] For these patients, whose number is gradually increasing, it is necessary to use another diuretic agent which has analogous diuretic effect without interference with carbohydrate metabolism.

In 1962, Schultz *et al.*[2] reported a new class of diuretic compounds of which ethacrynic acid (Edercin)* is one of the more potent. It is 2,3-Dichlor-4-(2 Methylenebutryl)-Phenoxyoletic acid (Fig. 1) and is chemically unrelated to the thiazide diuretics. The purpose of this paper is to report our experience with ethacrynic acid as a non-diabetogenic antihypertensive diuretic compared to hydrochlorothiazide, (Hydrodiuril, Esidrix, Oretic)** a well known and clinically effective thiazide diuretic which frequently results in diabetes mellitus.

In our study a group of twelve previously evaluated hypertensive diabetic patients from the Outpatient Clinic of Abington Memorial Hospital were selected and taken off all hypertensive medication and treated with placebo for four weeks. At the end of the fourth week, base line determinations were made, which included a fasting blood sugar and serum potassium. Then patients were given ethacrynic acid, 100 mg., hydrochlorothiazide, 100 mg., or placebo in a double blind crossover design for eight week periods. They were seen by physicians every two weeks, at which time blood pressures, physical signs and symptoms were recorded. Laboratory data was obtained at the twelfth, twentieth, and twenty-eighth weeks. The average age of the patients was fifty-eight years (range: 48-68 years). There were eleven females and one male; one negro and eleven Caucasians. They all had maturity onset diabetes.

The antihypertensive action (TABLE 1) as measured by a fall of 20 mm. in the mean blood pressure ($MPB = D + \frac{(S-D)}{3}$) shows a response rate in the standing posi-

* Merck, Sharp and Dohme.
** Merck, Sharp and Dohme, CIBA, Abbott Laboratories.

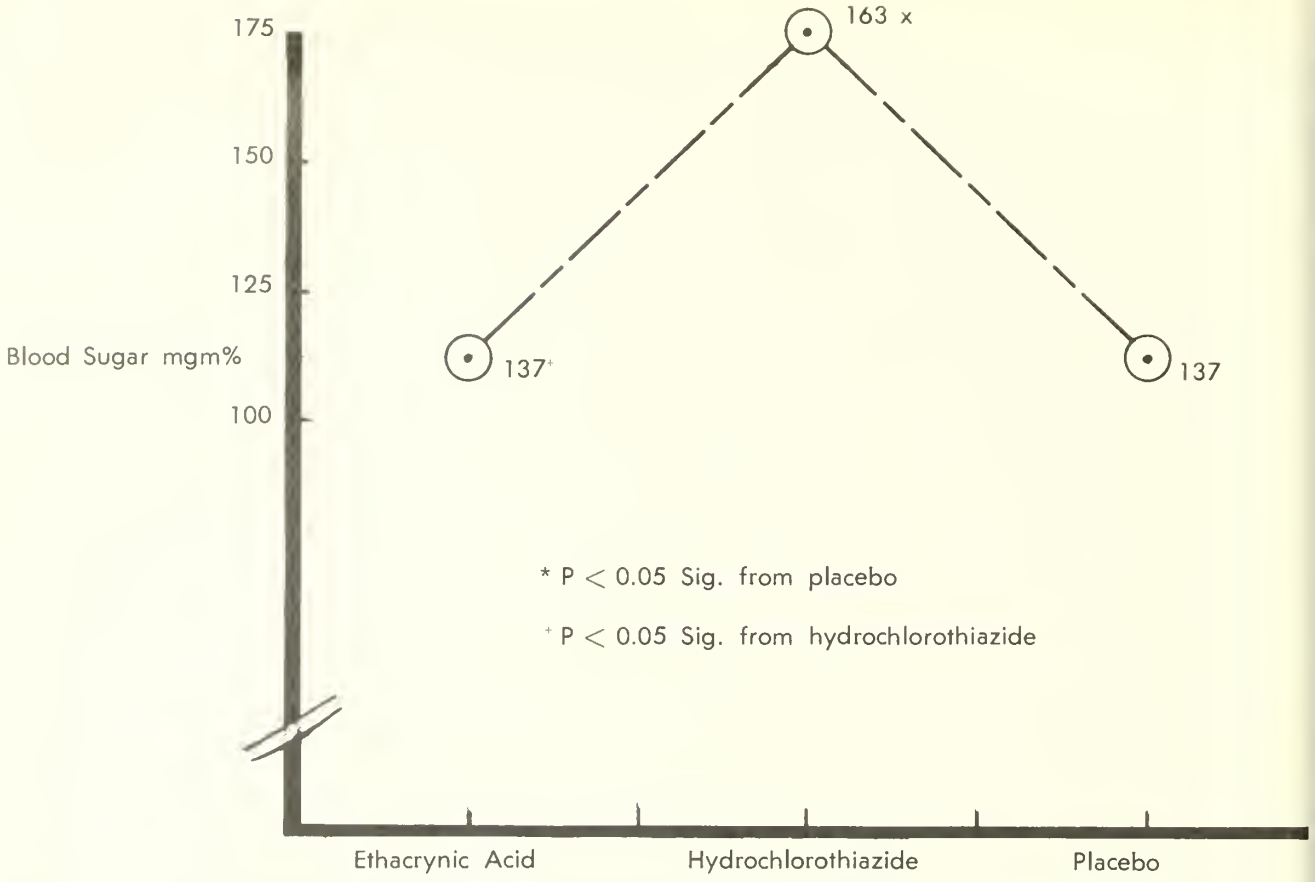

Figure 2. Fasting blood sugars for 12 diabetic hypertensive patients under indicated therapy for eight week periods.

tion for ethacrynic acid and hydrochlorothiazide of fifty percent, and placebo, 25 percent, none of which is significant. In the sitting position, the response rate is 50 percent for ethacrynic acid, 42 percent for hydrochlorothiazide, and 8 percent for placebo and it is significant for both agents. For the prone position, the response rate is 36 percent for ethacrynic acid, 27 percent for hydrochlorothiazide, and 9 percent for placebo and none is significant. Thus one can see a significant fall in the response rate in the sitting position for both ethacrynic acid and hydrochlorothiazide. This is comparable with at least six previously published reports [3, 4, 5, 6, 7, 8] on the antihypertensive action of ethacrynic acid which have shown small groups of hypertensive patients to be moderately responsive.

The blood glucose determinations were fasting blood sugars determined by the Auto Analyzer method and showed the following results (TABLE II). The blood sugars averaged 137 mgm percent for both ethacrynic acid and placebo, and 163 mgm percent for patients on hydrochlorothiazide. The blood glucose in the ethacrynic treatment period obviously was no different from placebo. However, the ethacrynic acid period was significantly different — $P < 0.05$ — from hydrochlorothiazide and the hydrochlorothiazide significantly different from placebo — P value being 0.05. Short term effects of ethacrynic acid on carbohydrate metabolism have been reported by Harriett Dige Petersen.[9] She has reported that in six diabetic patients ethacrynic acid doses up to 150 mg. a day for seven days did not influence the blood sugar. Our results (Fig. 2) continue to confirm the absence of hypoglycemic response with ethacrynic acid but presence with a thiazide.

Serum potassium levels which were also measured at the same time failed to reveal any significant difference, the placebo values being 4.21 mEq/L, ethacrynic acid values at 4.16 mEq/L, and hydrochlorothiazide values at 4.43 mEq/L.

In human patients Dollery [10] has shown that thiazide diuretics depress a so-called typical insulin-like activity of plasma thought to be identical with the insulin secreted from the pancreas and resulting in an elevation of fasting blood sugars in diabetic patients. This paper supports the findings that the thiazide diuretic, using hydrochlorothiazide as a typical thiazide, continues to be diabetogenic while ethacrynic acid does not seem to possess the same capacity. It was not within the scope of this paper to measure serum insulin-like activity.

Summary

In a double blind cross-over study, twelve diabetic hypertensive patients were given ethacrynic acid, 100 mg., hydrochlorothiazide, 100 mg., or placebo for three eight week periods. A significant antihypertensive action was seen with both drugs in the sitting position. The diabetogenic effect of hydrochlorothiazide was denoted by a rise of blood sugar to 163 mgm percent, while ethacrynic acid and placebo showed similar blood sugar levels of 137 mgm percent. This suggests that the depression of so-called insulin-like activity of plasma caused by the thiazide is not seen with ethacrynic acid and may be due to its being chemically unrelated to the thiazide. Thus diabetic patients in need of an oral diuretic antihypertensive agent could be given ethacrynic acid without inducing hyperglycemia.

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Dr. Hutchison is chairman of research, director of hypertensive research, and assisting visiting physician in cardiovascular service at Abington Memorial Hospital.

Blood Pressure		Ethacrynic Acid 100 mg.	Hydrochlorothiazide 100 mg.	Placebo
Standing	Mean	6/12 = 50%	6/12 = 50%	3/12 = 25%
Sitting	Mean	6/12 = 50%*	5/12 = 42%	1/12 = 8%
Lying	Mean	4/11 = 36%◙	3/11 = 27%	1/11 = 9%

No. Pt. Responsive / No. Pt. Tested	% of Response

* $P < 0.05$ Significant from placebo

◙ Placebo missing in 1 patient lying

$$\text{Mean BP} = D + \frac{S-D}{3}$$

TABLE I. The response rate (20 mmHg. fall mean BP) for 12 diabetic hypertensive patients on drugs indicated after treatment period of 8 weeks.

						Blood Sugar mgm%.		
			DIABETIC THERAPY			DRUG THERAPY		
Pt. No.	Sex	Age	Diet	Oral	Insulin	Ethacrynic Acid 100 mg.	Hydrochlorothiazide 100 mg.	Placebo
1	F	65			X	215	249	198
2	F	68			X	145	202	142
3	F	48			X	227	270	236
4	F	51		X		132	285	157
5	F	56		X		69	96	78
6	F	54		X		127	140	125
7	M	61		X		150	82	110
8	F	54			X	196	219	180
9	F	68		X		122	172	149
10	F	67		X		138	114	105
11	F	60	X			78	82	85
12	F	49			X	135	238	169
Aver:		58				137+	163*	137

+ Significant difference from Hydrochlorothiazide $P < 0.01$

* Significant difference from placebo $P < 0.01$

TABLE II. The Patients, Method Diabetic Control, Drugs Indicated and Fasting Blood Sugars for 8 week periods of therapy.

THE RESPONSI GAP

Symptom reduction often begins within the first week with AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

All antidepressants take time to work. With Aventyl HCl, patients who will respond often begin to receive symptomatic relief within the first week of therapy. They may report sounder sleep, better appetite, increased interest, or other noticeable improvement in mood or activity.

In a study of two tricyclic drugs, "nortriptyline was associated with a more rapid symptom reduction during the first three weeks of treatment."* However, the author also reported that although some differences in response existed after three weeks, "they were no longer significant by the sixth week of treatment."* *Of course, maximum improvement with Aventyl HCl, as with other antidepressants, may require longer therapy, particularly in severe depressive illnesses.*

Aventyl HCl may help shorten the response gap . . . provides measurable symptomatic relief your patients often notice and appreciate.

*Mendels, J.: Comparative Trial of Nortriptyline and Amitriptyline in 100 Depressed Patients, Amer. J. Psychiat., *124*:59 (Feb. Supp.), 1968.

10 mg.† 25 mg.† 10 mg.† per 5 cc.

†base equivalent

AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

Lilly

See next page for prescribing information.

900816

AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two weeks after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl HCl under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Patients receiving a tricyclic antidepressant (e.g., nortriptyline) may respond poorly to hypotensive agents such as guanethidine.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily
10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily
10 mg.—Ages three to six, 1 Pulvule one to three times daily
Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily
Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500. [081668A]

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DANIEL RANSOHOFF

Conservation of Hearing

Medical and Other Considerations

JAMES M. COLE, M.D.
Danville

Because of the detail of the overall picture and the complexity of a truly effective conservation of hearing program, this presentation will be given in outline form with emphasis on the physician's role in conservation of hearing, particularly that of the otolaryngologist. Also, I will discuss his relationship to the many other important workers in this field and to those who are interested in and support pertinent programs at a community level and also those having regional, state or national scope.

Neonatal

Conservation of hearing should start in the prenatal period or ideally in the premarital selection of one's mate if hereditary types of hearing loss are to be reduced in the future. I refer to such conditions as the Waardenberg syndrome and progressive types of hearing loss such as those associated with retinitis pigmentosa or progressive nerve degeneration types of inherited deafness. This is a difficult area for conservation of hearing but occasionally opportunities arise where help may be given in eugenic types of premarital counselling.

Prenatal

Maternal rubella has been a very difficult area for conservation of hearing and undoubtedly the problem of rubella in the first trimester will be with us until adequate immunization programs for the susceptible maternal population have been developed. We must encourage obstetricians and all physicians caring for pregnant women to avoid use of ototoxic drugs during pregnancy. In the last several years considerable gains have been made in the prevention and treatment of erythroblastosis fetalis due to Rh incompatibilities and these efforts will be reflected in the lowered incidence of children born with hearing loss and other defects due to erythroblastosis. There is evidence that the problem of hearing loss associated with prematurity is on the increase due to improved survival of premature infants. Probably all we can do to encourage conservation of hearing in this group of individuals is to point out the association of prematurity with hearing loss and probably with neonatal and postnatal anoxia. At one time there was enthusiasm for using prophylactic antibiotics including Streptomycin* and Dihydrostreptomycin* in premature infants and at least in our clinic we have seen a rather large number of children in whom apparently there was a relationship between prematurity and neonatal and postnatal use of these drugs. If we know of any medical colleagues who believe that there is a safe dose of Streptomycin and Kantrex,** etc. in newborn, especially in premature infants, we should do all in our power, including joint review of the pertinent literature on that subject, to dissuade them from this misconception.

Preschool Children

Parents of young children frequently suspect possible hearing loss and since evaluation of hearing in children of any age is now possible in sophisticated audiologic centers, physicians should learn to utilize these facilities when the question is raised in order that recognition of significant hearing

* Phizer Laboratories
** Bristol Laboratories

defects and early treatment can be started. There is currently considerable interest in testing children's hearing shortly after the time of birth and undoubtedly these programs should be encouraged by us.

Otitis media remains a very common childhood malady and although it is usually treated quite effectively by pediatricians, general practitioners and others outside the field of otolaryngology, awareness of the frequent association of these apparently short lived infections in this antibiotic era and the more subtle and relatively asymptomatic stage of secretory otitis media needs constant stress. If we will point out the importance of follow-up evaluation and especially a check of the mobility of the tympanic membrane following treatment for otitis media and other upper respiratory infections and especially if we will teach ourselves and our colleagues the indispensible role of the pneumatic otoscope in adequate otoscopic examination, then many more early cases can be recognized and early and effective treatment can be instituted. There is no doubt in my mind that secretory or non-suppurative otitis media and its sequelae have in the past been underdiagnosed and misunderstood regarding its very great importance in hearing problems in children.

Greatest difficulty in handling children with hearing loss is in the area of secretory otitis media

Virus diseases including epidemic mumps, epidemic rubella and perhaps to a lesser extent, epidemic influenza and other "adeno" and related virus infections are rather frequent offenders in causing sensorineural hearing loss, not only in children but also in adults. Currently the most susceptible population is being protected by immunization against epidemic measles; and, hopefully, a safe, effective mumps vaccine will be available for large scale immunization programs in the near future. Although we do have a mumps vaccine, it has not been thought to be safe enough to employ except for limited unusually susceptible populations. I am sure that most of us who deal daily with hearing problems in children recognize the mumps virus as the most frequent cause for severe hearing loss in children, fortunately usually only in one ear.

School Age Children

Conservation of hearing in school age children is helped significantly by the conservation of hearing program in the schools. The effectiveness of this program requires good working relationships between otolaryngologists, pediatricians, family physicians and personnel in the schools carrying out the program. The system may break down at any level but the one where we can be most effective in assuring success of the program is to be sure that children suspected of having hearing loss have adequate otologic and audiologic assessment and effective and prompt treatment when suspected hearing loss is verified. School nurses have every right to be upset with physicians who for a number of reasons do not effectively carry out their role in the program. This should include prompt return of reports to the school nurse that a diagnosis has been established and treatment has been instituted. At times nurses and audiologists have asked me what to do when children found to have hearing difficulties have been treated and are subsequently found to have residual significant hearing loss and especially when there is a suspicion that this is of a conductive or remedial type which should respond to medical treatment. The only suggestion I have is referral for further opinion to another physician or hearing center. This may lead to some embarrassment in professional relationships but should be very rare if physicians are alert to ask for consultation when needed or for competent opinions and evaluation when there is an indication of some uncertainty or dissatisfaction regarding treatment by members of the family or other interested parties including school officials.

The most difficulty in handling school age children with hearing loss, as noted above, is in the area of secretory otitis media. Effective treatment of this condition may, and, in fact, usually should, involve assessment of etiologic factors including: hypertrophy of the tonsils and adenoids, with or without signs and symptoms of chronic or recurring infection; the presence of palate problems including congenital short palate, bifid uvula and submucous cleft; the presence of allergies; other etiologic factors such as sinus disease, and evaluation of causative factors in the infection prone child such as inadequate nutrition, unfavorable housing, poor health habits and practices, and the presence of hypogammaglobulinemia.

In treating secretory otitis media, the role of clean tonsillectomy and particularly clean visually guided adenoidectomy should not be underrated as has been done at times by some of our colleagues. In my experience,

adenoidectomy is undoubtedly the poorest performed procedure relating to hearing, at least in central Pennsylvania. In my opinion, inadequate adenoidectomy is done when only an instrument such as the LaForce adenotome is used for removal of tissue in the nasopharynx. This usually results in removing the lower midline portion of the adenoid and often there may be compensatory hypertrophy of the upper remaining adenoid with nasal obstruction and more importantly as it affects hearing, lymphoid tissue remaining in Rosenmuller's fossae. Clean adenoidectomy can be accomplished with thin bladed curettes, starting the downward sweep at the posterior edge of the septum and at least one lateral swipe starting the instrument snugly against the posterior and superior projection of the torus of the eustachian tube. Punches and ring forceps visually guided may be of significant help at times. A sidelight of clean adenoidectomy is that postoperative nasopharyngeal bleeding will seldom be a problem if the procedure is properly done.

We have found the use of tympanostomy tubes, either the flanged or collar button types, to be of considerable help in clearing the gluey secretions of chronic secretory otitis media so frequently seen in children. Proper allergic management of the atopic child is a necessary part of efficient clearing of secretory otitis media in many individuals. It should go without saying that adequate audiologic pretreatment and follow-up control of children with otitis media, of whatever variety, is fundamental to intelligent medical management.

Unresolved Otitis Media

Unfortunately, the problem of chronic suppurative otitis media, unresolved secretory otitis media and cholesteatoma is a present problem. There is no doubt in my mind that cholesteatoma is often related to unresolved secretory otitis media especially in the atelectatic ear. However, attic invasion with squamous epithelium may be very subtle and is easily overlooked. In the past several years I have seen a surprising number of children apparently having an intact tympanic membrane with cholesteatoma filling the middle ear, often with significant involvement or destruction of the ossicular chain. Most of these ears require microsurgical treatment for elimination of chronic disease, repair of tympanic membrane and ossicular chain loss and maintenance or restoration of hearing with production of a dry, safe ear. Any management less than this is not compatible with the current standards in medical and otologic management of these problems.

The opportunities for conservation of hearing in adults having chronic ear pathology are essentially no different than those in children. It is unfortunate that apparently many lay people and a few physicians have been taught or led to believe that chronic suppuration of the ear is not necessarily an unhealthy situation. Nor do they appreciate the dangers, not only to hearing but often in a more basic sense, that the chronic draining ear is often associated with the possibility or potentiality for serious and life threatening complications. Fortunately, those of us who treat large numbers of hearing impaired individuals frequently have the opportunity to eliminate serious ear problems such as middle ear and mastoid cholesteatoma with an excellent chance of preservation and improvement in hearing. If these individuals are not referred by their family or other physicians, indeed the first time the possibility of a dangerous ear condition has been pointed out is when they consulted the otologist to determine whether hearing might be improved.

Noise Induced Hearing Loss

As physicians interested in conservation of hearing we should do everything possible and undoubtedly more than we are currently doing in prevention of hearing loss through exposure to noise. The possibilities include industrial noise abatement and control, protection of hearing in the sports shooter, protection of hearing in military personnel and noise control in areas such as the farm, fireworks, and noisy toys where preventive measures are available and too infrequently applied. Severe labyrinthine concussion with resulting hearing loss as is seen in head injuries and severe blast concussion, present serious limitations in applications for prevention. Perhaps as new applications of automobile safety standards and improved restraining belts are used, we will see fewer cases of head injury and associated hearing loss from this cause.

Other Adult Onset Hearing Loss

We need only mention the excellent possibilities for restoration and conservation of hearing in most individuals who have otosclerosis. Surgical results indicate the possibilities for elimination of the conduction portion of hearing loss in over 90 percent of individuals with stapes surgery (within 10 decibels of the cochlear reserve). This surgery is not without some slight risk for further hearing loss. In skilled hands it probably does not exceed 1 percent.

Meniere's disease, manifesting as either labyrinthine or cochlear hydrops, remains a very common condition usually affecting those in the most productive time of their lives. Some pessimistic opinions to the contrary, the experience in our clinic and others indicates that medical management with conservation of hearing seems possible at least for preservation of useful aided or unaided hearing in 90 percent of individuals so affected. Those having bilateral involvement (10 percent) and the group who do not respond to medical management are a problem and whether some of the newer types of surgery will be helpful in overall control of disabling symptoms and specifically in conservation of hearing, is currently only partially solved. I have a strong feeling that this disease should fall within the diagnostic, therapeutic and supportive province of the practicing otologist as he is the one who is best able to accurately make a diagnosis, appreciate its implications and deal with its many manifestations.

We recognize sudden hearing loss as etiologically being due to viral diseases, circulatory problems including thrombosis, hemorrhage and blood sludging. We should not overlook the possibility of the presence of blood dyscrasias, leukemia, etc., as an etiologic factor occasionally in sudden hearing loss. The otologist should be prepared to recognize the various types and undoubtedly vigorous early medical treatment at times is helpful in recovery of hearing.

Ototoxic Drugs

We should avoid these drugs Streptomycin (Dihydrostreptomycin),

Kantrex, Neomycin† and others except in life threatening infections where there is no available or effective alternative. When used they should be limited to a dose which is reasonably safe and adequate kidney function must be established to avoid dangerously high blood accumulations. It is really tragic to see severely hearing handicapped individuals who have been given these drugs for treatment of trivial conditions like the common cold. Several years ago I saw a physician's secretary who was given three times the accepted safe dose of one of the drugs for treatment of a cold so that she might "enjoy" her vacation. Obviously we must exercise considerable vigilance in our own and in our colleagues' practices in limiting these drugs only to the indications as noted above.

Acoustic Neurinoma

Recently the subject of acoustic neurinoma has been frequently discussed. Due to the current interest in hearing, we often have a unique opportunity to diagnose this important condition early in its course. Appropriate treatment of early acoustic neuromas often may permit conservation of hearing and preservation of important functions. Complete assessment of all persons having unilateral sensorineural hearing loss, especially of the neural type, should include complete audiologic study with all necessary special tests to attempt to pinpoint the site of lesion. Vestibular function studies and X-rays of the internal acoustic meati with contrast media by posterior fossa myelography in doubtful cases make up the minimal and acceptable work-up for all cases in which a complete battery of studies is necessary to arrive at an accurate or exclusion diagnosis.

Presbycusis is the most common hearing problem in our aging population and currently and probably in the foreseeable future management will be largely one of measures to permit optimum use of residual hearing.

Research

Although a good deal is known about treatment and prevention of hearing loss, further basic information is needed regarding many types and forms of hearing problems. Active support of The Deafness Research Foundation, the research activities of The American Otologic Society, The American Academy of Ophthalmology and Otolaryngology, and government support of research through The National Institute for Neurologic Diseases and Blindness should be encouraged.

† Eli Lilly Co.

Conservation and Rehabilitation Surgery

Besides the possibilities for improving hearing through stapes surgery, tympanoplasty and conservative mastoid surgery coupled with tympanoplastic repair are proving increasingly effective and are approaching the stage where a very high percentage of conductively handicapped individuals may be rehabilitated in this manner. Microsurgical techniques and early diagnosis also permit early diagnosis of glomus jugularis tumors, effective control, and hearing conservation.

Physician Education

Undoubtedly undergraduate and graduate education in ear and hearing problems and rehabilitation techniques has been inadequate in the past. If maximum effectiveness in a hearing conservation program is to be realized, physician education should be a very important facet of it. Our undergraduate population should have adequate instruction in the diseases of the sensory organs, including the ear, and as a minimum should understand the rudimentary diagnostic examination methods. That there is considerable interest in this field is evidenced by the lively competition of physicians seeking training in otolaryngology. Many of the physicians applying to the program at the Geisinger Medical Center are top students in the leading medical schools, not only in this State but from all over the country and many foreign countries as well. I am sure that this is true in other programs in the state. Undoubtedly more good residency programs should be available for training in the field of otolaryngology. It is likely that postgraduate courses in updating the practicing otolaryngologists would be helpful. Undoubtedly interest might be generated in short courses for practitioners in other fields who are interested in basic concepts and techniques appropriate to them in otolaryngology with consequently more widespread interest in hearing conservation. We should all encourage our physician colleagues to be aware of possibilities in prevention, treatment and recognition of ear and hearing defects in their patients which must be important to them since reliable authorities tell us that hearing problems are the most prevalent physical disability in our general population.

Dr. Cole is chief of the section of otolaryngology and broncho-esophagology at the Geisinger Medical Center. He is a diplomate of the American Board of Otolaryngology and chairman of the conservation of hearing committee of the Pennsylvania Academy of Ophthalmology and Otolaryngology.

Rehabilitation

I have alluded to medical and surgical rehabilitation possibilities and as physicians we should give support and encouragement to our educational colleagues, guidance and assistance to hearing aid dealers and those interested in vocational rehabilitation.

Preventive Medicine

We should encourage and support programs in noise control and abatement not only in industry but in sports and other areas where loud noise poses a threat to hearing.

The job is too big for physicians alone, for audiologists alone, for teachers of the deaf alone or for prosthetic manufacturers and salesmen. Cooperative interdependent efforts need support by all physicians, by audiologists, by educators, by governmental agencies, including the program of the Department of Health, by the Bureau of Vocational Rehabilitation and by welfare agencies assisting in the care of the medically indigent. Speech and hearing centers are playing a large role in community conservation of speech and hearing and guidance in training and in rehabilitation. Programs of voluntary agencies, hospital and government agencies are important. Our legislators should be encouraged to support programs which will further an effective hearing conservation program.

Sexual Dysfunction

and Psycho-physiologic Illness

PAUL J. POINSARD, M.D.
Philadelphia

The universal interest in sexuality comes into clinical focus when dysfunction occurs. Frigidity, vaginismus and dyspareunia in the female and impotence and premature ejaculation in the male are the most common dysfunctions. This presentation will not consider sexual abberations and perversions but only those cases of dysfunction in professed heterosexual adults. The thesis that sexual performance is a psycho-physiologic (mind-body) manifestation will be established, without reference to specific case material.

Disturbance in the psycho-physiologic relationship leads to sexual dysfunction. With the exception of occassional physical causes these disturbances consist of psychological conflicts that interfere with total "mind-body" interaction and expression.

In studying human sexual response,[1] the computer approach offers perspective. "Input and output" must be studied. Studying genital response relates to output from which we can learn the presence or absence of dysfunction. In studying input we learn of the faulty or missing life experiences that creates pathology or the positive experiences fostering healthy sexual functioning. It is in the processing of the data between "input and output" that emergent response provide our understanding of etiology.

It is interesting to consider that by the time of adult sex experience the "programing" of the individual's sex response is complete. Each "input" will reach an almost identical "output". The delicate process of re-direction when dysfunction occurs requires a thorough knowledge of past experiences responsible for the faulty programing.

The infant is born with capacities for feelings among which is sensuousness. These are enhanced and embellished or thwarted and stifled by parental, religious, educational and cultural influences. Capacities for excitation, expectation, anticipation and adventure must be accessible for complete sexual involvement. The partial instincts of looking, tasting, smelling, hearing and touch should not be stripped of their sexual linkage and laden with taboos and misconceptions.

The form his development takes is due to influences of the early physical and emotional environment. He becomes a composite, a mosaic of social, moral, cultural and educational concepts. All forces have their particular way of influencing the development of sexuality. These factors deserve equal importance to inherited and constitutional ones. There is no longer a tendency to explain sexual dysfunction on a genetic basis.

There are myriad mental and emotional nuances of a maturational and adaptive nature occurring during adolescence.[2] Lorand [3] states it well by saying the most intense struggle of adolescence is the detachment from parental authority. It is the crucial time for extension of ego development, concept of self, sexual identity and search for a way of life. It is the time of crystalization of Ego Ideal and Super Ego, often associated with severe critical value judgments of self, peer groups and adults. Concurrently, patterns of reaction to moral and social demands develop. At the same time it is a test of the nature of the identification with parent or parent substitute. Will the identification be primarily masculine or feminine? Will the psychological gender be the same as the biological? Reports from the Identity Research Clinic of the University of California School of Medicine suggest that American society is growing more feminine as it grows more complex.[4] The capacity of the adolescent to relate to other humans with or without constancy now appears. The constancy of object relatedness is a direct measure of the absence of ambivalence, i.e., of mixed feelings, love, hate and fear—ambivalences which are acquired from his early object relations.

Sex and Art

The reflection of things a person learns when he is younger find expression in art. Art, like sex, uses the body or parts of the body to portray a mental concept. Factors involved in creativity with the portrayal of mental images through the use of physical faculties has an analogy in sexual expression. "Art expressed in the medium of painting is most accurately interpreted through the meaning it has to the artist." [5] If the word "sex" is substituted for "art", it reads, "Sex expressed in the medium of coitus is most accurately interpreted through the meaning it has to the person. It may be simple or complex, lighthearted or sad, a form of communication to express a message to one or many, often of love or hate. The artist may wish to draw attention to himself, a selfish form of expression to obtain praise. It may be an attempt to fill the void in an empty world that contains people whose existance seems pointless and ends only in death. The message may be a portrayal of an inner fantasy; morbid from the depressive, contemplative or adorational from the esthete or destructive from the anarchistic."

Satisfaction

Sexual satisfaction can be achieved in a variety of ways. The intensity or height of feeling is subjective and unmeasurable. The gradients of satisfaction and fulfillment range from a masturbatory experience in which the self is the object through homosexual experience and perversion to coitus involving a heterosexual partner.

A psycho-physiologic expression is reflected in coitus enhanced by the capacity for ego regression to loss of control. A fusion of mental and physical faculties occurs with loss of ego boundaries, devoid of anxieties of threats to identify or self esteem.

In the adult, "psychologic sets" arrived at by heredity and environment determine the choice of object. Arrests or disturbances in psycho-sexual

development may prevent the choice of a heterosexual object and interfere with functioning even after arriving at apparent heterosexual development.

Capacity for mature object relations is essential to total sexual expression (of a non-neurotic type). Giving and receiving in both parties enjoys a healthy equilibrium. (In a recent study Gebhard [6] reported that only 4.4 percent of the wives in extremely happy marriages have not experienced orgasms in marital coitus. Other factors such as length of foreplay, and duration of penile intromission were considered.) There are no anxieties about total submission and helplessness. The power struggle is minimal and aggression used as a form of sexual expression rather than the need for control. The aims and goals are primarily for satisfaction of self and partner rather than using the sexual encounter for acting out a drama often unrelated to the object. In such cases the object is a vehicle rather than an intimate partner in the union.

The Female Role

The attitudes and feelings with which a woman receives the penetration of the penis and the deposit of sperm, to a large measure determine the presence or absence of psychophysiologic disorders of the vulvovaginal tract, excluding, of course, the presence of anatomical abnormalities or intercurrent organic disease.[7] What then are these important feelings and attitudes that determine the absence of psychogenic disorder?

First, the woman must have no doubt as to her female role and identity. She must accept this and wish it in all areas of her conscious and unconscious mental and emotional makeup. She must have no complex regarding masculine competition, sibling rivalry, homosexuality, or unresolved father or mother attachments, that reflect arrested psychosexual development.

Second, she must have the capacity to love and to be loved. The absence of love in a total sense including the love of the male body, his genitalia and its contents, can lead to vulvovaginal dysfunctions. For most women, in order to feel free, relaxed and receptive in coitus, it is also essential that they feel loved by the male. The absence of such feeling on either side is apt to lead to superficial acts, often unsatisfactory, devoid of complete fulfillment and gratification.

To the healthy woman, capable of loving to its full meaning, without conflict and ambivalence, the penis and sperm become an extension of the gift of love. She now has part of the loved object inside of her to be intermingled with her own substance and later returned at a pace defined by nature as her contribution to the creative union. The fetus, and later baby, is loved as its father was loved, and nursing proceeds as a joyous experience.

In considering the subject of sexual responses in women, Kinsey [8] states, "The percentage of married women who do not arrive at orgasm during marital coitus, range from 25 percent, beginning in the first years of marriage, with a gradual decrease to 11 percent in the twentieth year of marriage." This was based on a study of over a thousand cases.

Sex and Religion

It is significant that in his sampling of women in various religious groups that the most devout females were deriving a somewhat higher percentage of orgastic experiences in their marital coitus.

It has been frequently observed that the truly feminine person is religious. Religion as used in this context might be defined as the capacity for devotion, but not necessarily affiliation with a recognized religious group. The capacity for devotion is a facet of a mature ability for sustained object relations. Whether this capacity for devotion is directed to God or to the man to whom she is married, it reflects the feminine character with the capacity of complete and total involvement with minimal conflict.

This is not to say that the frigid woman may not be religious. It does say that her object relationship, whether to God or man or both, is apt to be of a different nature. Her orientation is possessive and demanding rather than receptive and giving. She is related more to "things" rather than to the essence of human values and relationships.

Frigidity

Unquestionably, some totally frigid women appear to communicate the veneer of all of these qualities commonly ascribed to feminity. She appears generous, loving, maternal and receptive, yet her capacity to achieve orgasm is completely lacking. This type of woman is successfully reflecting the facade of superficial defenses rather than communicating the structure of her inner being. Because of her orientation to things, schedules, maintenance of an orderly home and meticulously dressed and behaved children, the fundamentals inherent in a successful relationship to her husband are apt to receive secondary and minimal attention. In such cases if marital conflict ensues, such a woman frequently takes a defensive position and is perplexed, confused and angry that her position be challenged, when according to her, it is apparent to all that she is such a devoted wife and mother. Neurosis defended on the basis of "goodness" is an evasive culprit and extremely difficult to bring out in the open so that it might be looked at from all points of view.

The term "frigidity" describes a wide spectrum of manifestations from complete absence of orgasm during coitus to occasional orgasm, to clitoral orgasm induced by external manipulation, to cases in which a woman may be completely frigid with one adequately performing male and not another. It runs the gamut from being associated with pleasurable sensation to minimum pleasure to total absence of gratification and even in some cases to revulsion.

To quote Kleegman,[9] "A woman who has had the experience over and over again of being thoroughly aroused and not having achieved orgasm, is a candidate for many gynecologic symptoms. In an appreciable number of women, nature will adjust this situation with the protective mechanism of absolute frigidity. As response lessens, coitus is avoided or rejected, or else feeling is simulated, often with mounting resentment."

A frigid woman has learned to fear physical love, to run from it.[10] This fear has profound repercussions on her relationship with men. The reason for her fears are often locked in her unconscious mind. Consciously, she may wish above all things to achieve real closeness with her husband, to give and receive the greatest of all mutual joys between man and woman, sexual gratification, but she hasn't the capacity to receive this joy. It is beyond her will and control.

The ability to have a full orgasm is in most cases the hallmark of the psychologically mature woman. It is a sign that she has successfully weathered the storms of childhood and youth and has come unscathed into full womanhood with all that it implies.

Frigidity, with its often concomitant lack of interest and even revul-

sion, may lead to extra-marital promiscuity and an increased divorce rate. This fact continues to create additional social and religious problems far removed from its primary medical base.

Fear, guilt and anger are feelings that inevitably find their way into the marital relationship and often produce a symptomatology of frigidity. Despite the prevalence of the symptom, it is a topic that receives minimum consideration in most medical school teaching. Emotional problems in patients that generally require the major portion of the physician's time receive a minor emphasis in his medical school work.

Moral Attitudes

The interjection of personal moral attitudes in medical and scientific discussions severely hinders objective and dispassionate consideration of this important subject.[11] As confirmation, we sometimes see in medical articles such adjectives as "evil", "good", "bad", "degrated", applied to sexual phenomena. The authors of these articles have unwittingly intruded their own personal values and judgment into their data. It is not intended to criticize moral judgment but to point out that more confusion than clarification usually results when morals are mixed with concepts of disease.

The medical profession must share some of the responsibility for neurotically-laden attitudes about sex. In the not-too-distant past, barbaric procedures were instituted and prescribed in an attempt to eradicate what we now recognize as a symptom of underlying emotional disturbance. (Pious statements by recognized experts, with unsupported evidence, made such claims as "excesses" could lead to insanity. We now know that in such cases, if insanity ensued, the "excesses" were a result of the underlying problem that eventually led to the mental derangement rather than the cause.)

In medical literature there appears the following recommendation for female masturbation: amputation and cautery of the clitoris, restraining devices resembling straight-jackets to make the genitalia inaccessible to the hands, ways in which the wrists may be suitably tied or handcuffed, sewing the labia together, even castration. It is significant that there are no references in the literature to surgical removal of testicles or amputation of the penis to stop masturbation in males. One wonders if the policy would have been different and what treatment would have been proposed for boys if women instead of men were in the policy-making levels of the medical and legal professions at that time.

There is little question, generally speaking, that the girl is treated more rigidly in our society than the boy. As a result, the girl is more apt to be inhibited sexually, although there is much evidence to substantiate the fact that this is less so than in the past. In our culture no other basic need is so warped and distorted with superstition, prejudice and misconception. This stems from anxiety-ridden attitudes rather than clear-cut thinking. Taboos, punitive measures, threats of rejection, isolation, even murder, are not uncommon associations in the sexual life of the average person. In all phases of psychosexual development the suppressing and punitive social forces, both parental and extrafamilial, such as church, school, legal and local standards, tend to force conformance to frustrating and emotionally disturbed standards of sexual behavior.

Frustration and inhibition are essential parts of the socialization process, ego formation and object relations. Some restrictions of the child's sexual urge is therefore essential. Most psychiatrists agree that sublimation is necessary in our society. They make a plea for educating and guiding the child in such a manner that as an adult he does not pay the penalty of fear and guilt-laden attitudes condusive to neurosis associated with sexual adjustment.

Dyspareunia

Dyspareunia (painful coitus) is properly defined as a symptom, not a disease entity. While it may be, and frequently is, a neurotic symptom these women deserve a complete and careful study to rule out the presence of physical causes. Pain may result from organic difficulties and physiologically determined causes such as insufficient lubrication and anatomical abnormalities. Frequent disappearance of dyspareunia following childbirth may have a psychological explanation, but often suggests the correction of the difficulty as a result of anatomical changes subsequent to the mechanics of childbirth. While there continue to be varied opinions, most present-day experts agree that dyspareunia results more frequently from local lesions; however, many of these cases have psychogenic causes.

Vaginismus

Vaginismus may be described as a spasm of the circumvaginal and perivaginal musculature. It may be compared to the tight blink of the eyelids when a threatening motion toward the eye is perceived. Some authorities maintain that this is not necessarily the result of emotional conflict or neurosis and that no teleological factors are necessary for an understanding of vaginismus as there would be in considering neurosis. In this sense it is considered a conditioned reflex. On reflection it becomes apparent that there are great psychological differences between the entrance of an unwanted, irritating, inanimate foreign body in the eye and the entrance of the penis into the vagina in marital coitus. To be frightened of the penis and all the potential implications of its presence is a much more inclusive consideration of the phenomenon of vaginismus than that of the conditioned reflex. Unwillingness to assume the adult role because of reluctance to give up an infantile position, fear of pregnancy, fear of venereal disease, fear of being hurt and other anxiety-laden feelings are usually more accurate explanations.

Spasms may occur not only when an attempt at coitus is made but also when the physician attempts to induce the examining finger. Early childhood experiences may provide the symbolic allergen for the later adult responses. The insertion of painful suppositories, soap sticks, or enema tips may have paved the way for this painful adult eventuality. The baby who is repeatedly attacked in this way will scream and stiffen at the very sight of the attacking object. There is a suggestion then of conditioning at an early and impressionable age. It has been noted that wives with vaginismus have a high incidence of husbands who are passive dependent personalities who have impotence or premature ejaculation. The unconscious choice of this type of marriage partner may also be intimately involved in the psychopathology that is reflected in vaginismus.

Impotence and Premature Ejaculating

Impotence and premature ejaculation in the male must be understood as they relate to each case. Generalities regarding causes are not applicable. Understanding the important influential life experiences together with their mental and emotional deri-

vatives is required in each case. Certain drugs and debilitating or anxiety producing physical illnesses may occasionally be the cause. Conscious and unconscious etiological factors can be numerous and varied. Unresolved parental attachments with resultant guilt, fear of punishment and fear of failure may present psychic barriers to complete functioning. The unconscious linkage of sex and aggression; in which the sexual act becomes equated with hurting or killing may serve to inhibit heterosexual intercourse. Loss of love with real or fantasied interest in another woman or homosexual interest may serve as an explanation. The male may wish to function as the passive partner and thereby withhold masculine assertion or express masculine supremacy and sadism by withholding an erection or ejaculation. He may unconsciously identify the sexual partner with a punitive threatening authority (usually parental) from the past all thereby be unable to function or he may fear the responsibility of parenthood or venereal disease. Just as the female may fear the penis and its contents, the male may have conscious or unconscious misgivings about the dangerous vagina and its interior, with concomitant revulsion and disgust leading to dysfunction. The real or imagined ghosts of the past continue to influence his psyche preventing an uninhibited sexual performance.

Summary

The universal interest in sexuality comes into clinical focus when dysfunction occurs. Disturbance in the psycho-physiologic relationship leads to sexual dysfunction. Capacity for mature object relations is essential to total sexual expression. A psychophysiologic expression is reflected in coitus with the capacity for ego regression to loss of control. There is a fusion of physical and mental faculties. Sexual satisfaction can be achieved in a variety of ways. The intensity or height of feeling is subjective and unmeasurable. The gradients of satisfaction and fulfillment range from a masturbatory experience in which the self is the object to coitus involving a heterosexual partner. A total submission devoid of the need to dominate or control is essential in the female.

Impotence and premature ejaculations in the male; frigidity, vaginismus and dyspareunia in the female are the most common symptoms of sexual dysfunction. Sexual functioning is a mind-body manifestation.

Dr. Poinsard is professor of psychiatry and director of the division of postgraduate education at Jefferson Medical College. He is chairman of the Commission on Mental Health of the Pennsylvania Medical Society.

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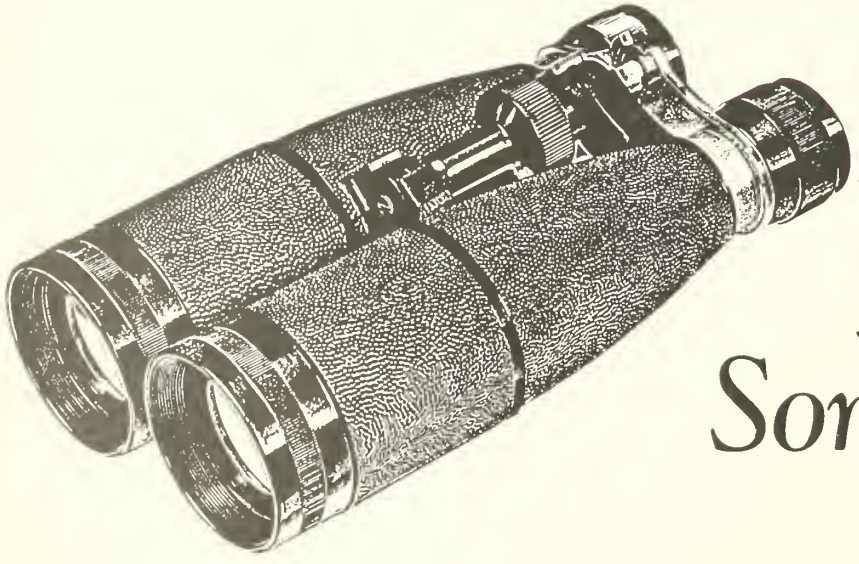

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ARTHRITIS AND RHEUMATISM

November 12, 1969; Philadelphia

C—**The Painful Shoulder and Painful Back;** at Albert Einstein Medical Center; 6 hours AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Chrmn., Educ. Comm., AEMC, York & Tabor Roads, Philadelphia 19141.

CARDIOVASCULAR DISEASE

November 6, 1969; Pottsville Hospital

I/AMA—**When to Operate for Hypertension** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 20, 1969; Altoona Hospital

I/AMA—**Myocardial Infarction, Consecutive Case Conference** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

CHEST DISEASES

September *24-26*, *1969*; Cleveland, Ohio

C/S—**Clinical application of Pulmonary Physiology (The Cleveland Course in Pulmonary Diseases);** by Case Western Reserve Univ., at St. Luke's Hosp. Fee $100 ($75-Amer. Thoracic Society members). Contact Joseph M. Foley, M.D., Continuing Med. Educ., Case Western Reserve, 2107 Adelbert Rd., Cleveland 44106.

October 16, 1969; Williamsport Hospital

I/AMA—**Clinical Pulmonary Physiology and Its Relation to Treatment** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 10-21, 1969; Philadelphia (Repeat February 9-20, 1970 and April 6-17, 1970)

PG/AMA—**Postgraduate Course in Bronchoesophagology;** at Temple; for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. $350 fee. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

DERMATOLOGY

September 29 to December 1, 1969 (10 Mondays); Philadelphia

I—**Dermatology;** at Albert Einstein Medical Center; 25 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Chrmn., Educ. Comm., AEMC, York & Tabor Roads. Philadelphia 19141.

November 20, 1969; Williamsport Hospital

I/AMA—**Office Management of Common Dermatologic Problems;** (Postgraduate Seminars held 3rd Thurs. ea. mo.); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

ELECTROCARDIOGRAPHY

October 8, 1969 to January 28, 1970 (14 Wednesdays); Philadelphia

I—**Basic Electrocardiography;** at Albert Einstein Medical Center; 42 hrs. AAGP credit; $100 fee. Contact Solomon Mintz, M.D., Chrmn., Educ. Comm. AEMC, York & Tabor Roads, Philadelphia 19141.

GENERAL MEDICINE

Every Thursday; Hazleton State General Hospital

I—**Program of Continuing Medical Education by Hazleton Branch. Luzerne County Medical Society.** Contact Robert Gunderson, M.D., Suite 412 Northeastern Building, Hazleton, Pa. 18201.

August 14 & 15, 1969; Fort Washington

C—**Symposium on Sports Medicine;** at Germantown Academy; 16 hrs. AAGP credit; $50 fee. Contact David G. Moyer, M.D., Germantown Academy, Fort Washington 19034.

September, 1969-May, 1970; Philadelphia

PG—**Retraining Program for Women Physicians;** at Woman's; 6 hrs. a day, 3 days a week, 35 weeks, no fee. Contact Ethel Weinberg, M.D., Woman's 3300 Henry Ave., Philadelphia 19129.

September 4, 1969; Pottsville Hospital

I/AMA—**Clinical Implications of Newly Discovered Hormonal Agents** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

September 12, 1969—Williamsport Hospital

I/AMA—**Fevers of Unknown Origin in a Pediatric Population** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP Credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

September 15-18, 1969; Lancaster

C—**"Clinical Therapeutics—1969";** by C E S; at Host Farm Resort Motel. Fee: $10. Contact John H. Killough, M.D., PMS—Taylor Bypass and Erford Rd., Lemoyne 17043.

September 18, 1969; Bethlehem

I/AMA—**Immunology: Basic Concepts** (Program of Continuing Medical Education) by Jefferson and Penn State; at St. Luke's Hospital; 3 hrs. AAGP Credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 2, 1969; Pottsville Hospital

I/AMA—**Preoperative Evaluation to Prevent Postoperative Complications** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 2, 1969; Altoona Hospital

I/AMA—**Obstetric and Gynecologic Endocrinology** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

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C E S—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Penn-Grad—University of Pennsylvania, Division of Graduate Medicine
Pitt—University of Pittsburgh School of Medicine
Pitt P.H.—University of Pittsburgh Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania School of Medicine
Woman's—Woman's Medical College of Pennsylvania

October 9, 1969; Bethlehem

I/AMA—**Congenital Absence of the Thymus and Its Immunological Consequences** (Program of Continuing Medical Education) by Jefferson & Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 10, 1969; Williamsport Hospital

I/AMA—**Hepatitis;** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 15, 1969-December 3, 1969 (Wednesdays); Philadelphia

I/AMA—**Recent Advances in Medicine;** at Temple; 32 hrs. AAGP Credit; $50 fee. Contact Albert J. Finestone, M.D., Dept. of Med., Temple, Broad & Tioga Sts., Phila. 19140.

October 16, 1969; Altoona Hospital

I/AMA—**Hepatitis, Consecutive Case Conference** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

October 16, 1969; Wilkes-Barre General Hospital

I/AMA—**Disease of Laboratory Origin** (Program of Continuing Medical Education—One Thursday each month); by Jefferson & Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 23, 1969; Bethlehem

I/AMA—**Vascular Response to Altered Immunity** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 2, 1969; Philadelphia

C—**Third Annual J. Herbert Nagler Memorial Symposium;** by Philadelphia Academy of G.P.; at Holiday Inn; $10 fee; 6 hrs. AAGP credit. Contact Milton W. Perloff, M.D., 2923 W. Cheltenham Ave., Philadelphia 19150.

November 6, 1969; Altoona Hospital

I/AMA—**Medical and Surgical Approaches to Inflammatory Lesions of the Colon** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 14, 1969; Williamsport Hospital

I/AMA—**Hormonal Contraceptives—Indications and Contraindications** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

GENERAL

October 30-31, 1969; Philadelphia

C—**Blood cells as a Tissue** (Sixth International Tissue Research Conference); at Lankenau Hosp. Contact William L. Holmes, Ph.D., Div. of Research, Lankenau, Lancaster & City Line Aves., Philadelphia 19151.

HEMATOLOGY

November 12 and 13, 1969; Reading Hospital

C—**Two Days of Hematology;** AAGP credit applied for; $25 fee ($10 for interns, residents, fellows & students). Contact Charles J. Lusch, M.D., Reading Hospital, Reading 19602.

INTERNAL MEDICINE

September 18, 1969; Wilkes-Barre General Hospital

I/AMA—**Use and Misuse of Antibiotics** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

MALIGNANT DISEASE

September 18, 1969; Williamsport Hospital

I/AMA—**New Ideas of Cancer Detection and Treatment** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107

MICROBIOLOGY & IMMUNOLOGY

September-December, 1969, (3rd Thurs. ea. mo.); Bethlehem

I—**Immunology;** at St. Luke's Hosp.; by Jefferson; 20 hrs. AAGP credit; $20 fee (5 seminars), $7 each. Contact Michael L. Sheppeck, M.D., Med. Dir., St. Luke's Hosp., Bethlehem 18015.

OPHTHALMOLOGY

August 4-8, 1969; Pittsburgh

C/S—**The Management of Retinal Detachment;** by Pitt at Eye and Ear Hosp.; 8 hrs. per day, 4 days; $250 fee; Max. regis: 12. Contact W. Everett, M.D., Director, Eye and Ear Hosp., 230 Lothrop St., Pittsburgh 15213.

PEDIATRICS

October 22-December 10, 1969; Philadelphia

I/AMA—**Recent Advances in Pediatrics;** at Jefferson; 8 Wednesdays; 16 hrs. AAGP credit applied for; $50 fee. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia, 19107.

November 20, 1969; Wilkes-Barre General Hospital

I/AMA—**Fevers of Unknown Origin in the Pediatric Age Group** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

October 1, 1969 to February 25, 1970 (Each Wednesday); Philadelphia

I—**Medical Hypnosis;** at Institute of Pennsylvania Hosp.; 80 hrs. AAGP credit; $250 fee. Contact Sydney E. Pulver, M.D., Program Director, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

October 6—November 24, 1969; Philadelphia

S/I—**Therapy of Problems in Sexual Adjustment** (Continuing Education Program for Psychiatrists); at Institute of Pa. Hosp.; 8 weeks; $50 fee; registration deadline Sept. 15. Contact Gerald J. Margolis, M.D., Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

October 6—December 8, 1969; Philadelphia

S/I—**Behavior Therapy** (Continuing Education Program for Psychiatrists); at Institute of Pa. Hosp.; 10 weeks; $50 fee; registration deadline Sept. 15. Contact Gerald J. Margolis, M.D., Institute of Pa. Hosp., 111 N. 49th St., Phila. 19139.

October 6—December 8, 1969; Philadelphia

S/I—**Family Therapy;** (Continuing Education Program for Psychiatrists); at Institute of Pa. Hosp.; 10 weeks; $50 fee; registration deadline Sept. 15. Contact Gerald J. Margolis, M.D., Institute of Pa. Hosp., 111 N. 49th St., Phila. 19139.

October 1, 1969 to December 17, 1969 (Each Wednesday); Philadelphia

I—**Applied Office Psychiatry;** at Institute of Pa. Hosp.; 48 hrs. AAGP credit; $50 fee. Contact Sydney E. Pulver, M.D., Program Director, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Louis E. Almasy,** New Kensington; University of Pittsburgh School of Medicine, 1936; age 56; died April 15, 1969. He served in the Army Medical Corps during World War II and was a member of Alpha Omega Alpha, national honorary medical society. Survivors include his wife, a son, two brothers and two sisters.

○ **Abraham Cohen,** Philadelphia; Jefferson Medical College, 1925; age 69; died April 17, 1969. He was a rheumatologist, and was assistant professor of clinical medicine at Jefferson. Survivors include his wife and son.

○ **Carl C. Kuehn,** Harrisburg; Indiana University School of Medicine, 1941; age 56; died May 11, 1969. Dr. Kuehn was deputy secretary of health for the Commonwealth, and had served the Pennsylvania Department of Health for fifteen years. He was in charge of regional health functions and the establishments of county health units. He was a consultant to the Commission on Rural Health and was immediate past president of the Association of State and Territorial Directors of Local Health Services. Survivors include his wife, a son and a brother.

○ **Ambrose DeCuzzi,** Philadelphia; Temple University School of Medicine, 1932; age 77; died April 22, 1969. There are no survivors recorded.

○ **H. Gordon Guylor,** Wilkes Barre; Hahnemann Medical College, 1925; he was a veteran of World War I and past president of the Luzerne County Medical Society. He was born and lived his entire life in Wilkes Barre, where he served as president of the Wyoming Valley Hospital staff. He is survived by wife, three daughters, and two brothers.

○ **Isaac Humphrey,** Nanticoke; Jefferson Medical College, 1926; age 71; died May 14, 1969. He was a fellow of the American College of Surgeons, and was a veteran of World War I. Surviving are his wife, a son, Leigh Humphrey, M.D., Nanticoke, and a daughter.

○ **Harold J. Kinney,** Ligonier; Stritch School of Medicine, Chicago, Ill., 1938; age 59; died May 1, 1969. Dr. Kinney and his wife, Mary Kinney, M.D., practiced medicine jointly in Ligonier, where he participated in a number of youth activities, particularly with the Boy Scouts of America, which organization had honored him with two of its highest adult awards. In addition to his wife, Dr. Kinney is survived by five children.

○ **David W. Kramer,** Philadelphia; Jefferson Medical College, 1912; age 78; died May 13, 1969. He was a former president of the board of Philadelphia General Hospital and associate professor of medicine at Jefferson Medical College. He specialized in metabolic diseases and diabetes and organized the diabetes clinic at Jewish Hospital, Philadelphia. He is survived by a brother and three sisters.

○ **Robert M. Larkin,** Scranton; Jefferson Medical College, 1960; age 34; died April 22, 1969. From 1962 to 1964 he served as a captain with the Army in Viet Nam, where he treated combat casualties. He received the Combat Medic Badge for his service there. He was associated in practice with his father, Walter J. Larkin, M.D. He is survived by his wife, a son, two daughters, his parents, a sister, and a brother, Walter J. Larkin, Jr., M.D.

○ **Charles A. Ley,** St. Petersburg, Fla.; Cleveland Medical College, Cleveland, O., 1907; age 88; died April 7, 1969. He is survived by his daughter.

○ **Abraham B. Mapow,** Philadelphia; Temple University School of Medicine; age 61; died May 4, 1969. He had practiced medicine for thirty-four years, specializing as an ear, nose and throat surgeon. Surviving are his wife, a daughter, two sons and a sister.

○ **Harrison McGhee,** Kane; Jefferson Medical College, 1919; age 82; died May 1, 1969. He was honored by the McKean County Medical Society and PMS for a half century of service to the medical profession in 1965. He served with the Army in World War I and was president of the Pennsylvania Chapter of the Order of the Purple Heart in 1943. He is survived by his wife, two sons and a daughter.

○ **Gerald J. Peters,** Philadelphia; Jefferson Medical College, 1950; age 53; died January 20, 1969. No further information available.

○ **Lester L. Bartlett,** Pittsburgh; Jefferson Medical College, 1929; age 66; died June 17, 1969. He is survived by his wife, two daughters and one son.

○ **William H. Bell,** Brookville; Medical College of South Carolina, 1939; age 55; died May 17, 1969. He served with the Army Medical Corps in Europe during World War II. Surviving is a sister.

○ **Eugene F. Carpenter, Jr.,** Lansdowne; Hahnemann Medical College, 1925; age 71; died June 6, 1969. No further information is available.

○ **Carl W. Espy,** Pottsville; University of Pennsylvania School of Medicine, 1917; age 77; died June 3, 1969. He was a physician for fifty years, retiring in 1967. Survivors are his wife, three daughters and a son.

○ **William V. Fetcho,** Jennerstown; Stritch School of Medicine, Chicago, Ill., 1932; age 62; died May 23, 1969. He served in the Army Medical Corps during World War II, and was school physician for the Jenner-Boswell Joint Schools. He is survived by his wife, two daughters, one of whom is Carole Skorpinski, M.D., Philadelphia, and one son, William V. Fetcho, Jr., D.D.S.

○ **Rene A. Fontaine,** Pittsburgh; University of Rochester School of Medicine, Rochester, N. Y., 1950; age 46; died May 30, 1969. He was director of the laboratory at Homestead Hospital. Survivors include his wife and two sons.

○ **John N. Frederick,** Pittsburgh; University of Pittsburgh School of Medicine, 1918; age 76; died June 14, 1969. He was a fellow of the American Psychiatric Society and past president of the Pittsburgh Neuro-Psychiatric Society. His wife survives.

○ **Boyd W. Ghering,** Edinboro; University of Pittsburgh School of Medicine, 1924; age 73; died June 9, 1969. He is survived by his wife.

○ **Martin F. Guckaven,** Philadelphia; Jefferson Medical College, 1935; age 65; died May 16, 1969. He served as a lieutenant commander in the Navy during World War II. He is survived by his wife, a daughter and four sons.

○ **William B. Hetzel,** Westerly, R. I., Columbia University College of Physicians and Surgeons, 1913; age 82; died May 28, 1969. He is survived by his wife and two sons.

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Pamphlets: *Mental and Emotional Illnesses in the Young Child,* single copies free from National Institute of Mental Health, 5454 Wisconsin Ave., Chevy Chase, Md. 20015 . . . *Viral Etiology of Congenital Malformations,* 65 cents from Superintendant of Documents, U. S. Government Printing Office, Washington, D. C. 20402 . . . *The Medical School and the Community Health Center,* 40 cents from Superintendant of Documents, U. S. Government Printing Office, Washington, D. C. 20402 . . . *National Medical Audiovisual Center Catalog,* 75 cents from Superintendant of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

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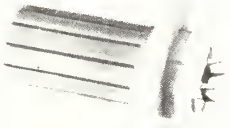

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meetings

AUGUST

PMS Board of Directors, August 13, 1969, PMS Headquarters, Lemoyne, Pa.

Eighth International Congress of Gerontology, sponsored by the Gerontological Society and the American Geriatrics Society, August 24-29, Sheraton-Park and Shoreham Hotels, Washington, D. C. Contact Secretariat, Congress of Gerontology, 9650 Rockville Pike, Bethesda, Md. 20014.

American Congress for Physical Medicine and Rehabilitation, August 17-22, 1969, Chicago, Ill.

American Hospital Association, August 18-21, 1969, Chicago, Ill.

SEPTEMBER

American Association of Obstetricians and Gynecologists, September 4-6, 1969, Hot Springs, Va.

American Society of Clinical Pathologists, September 14-21, 1969, Chicago, Ill.

Congress on Occupational Health, American Medical Association, September 15-16, 1969, St. Louis, Mo.

American Academy of General Practice, September 26-October 3, 1969, Philadelphia, Pa.

PMS Scientific Sessions, September 15-18, 1969, Host Farm Motel, Lancaster, Pa.

OCTOBER

Annual Otolaryngologic Assembly of the University of Illinois College of Medicine, October 4-10, 1969, at the Illinois Eye and Ear Infirmary, Chicago, Ill. Contact Otolaryngology, P. O. Box 6998, Chicago, Ill. 60680.

American College of Surgeons Clinical Conference, October 6-10, 1969, San Francisco, Calif.

PMS Annual Business Session, October 8-12, 1969, Marriott Motor Hotel, Philadelphia, Pa.

PMS Woman's Auxiliary, October 8-12, 1969, Marriott Motor Hotel, Philadelphia, Pa.

American Academy of Ophthalmology and Otolaryngology, October 12-17, 1969, Chicago, Ill.

Industrial Hygiene Foundation Annual Meeting, October 14-15, 1969, Chatham Center, Pittsburgh, Pa. Contact Robert T. deTreville, M.D., President, Industrial Hygiene Foundation, 5231 Centre Ave., Pittsburgh, Pa. 15232.

American College of Obstetricians and Gynecologists District Three Meeting, October 16-18, 1969, Pittsburgh Hilton Hotel, Pittsburgh, Pa.

Fourteenth Annual Conference of the Committee on Nutrition and Metabolism of the Philadelphia County Medical Society, October 22, 1969, Auditorium, Temple University Medical Center.

American Society of Anesthesiologists Annual Meeting, October 25-29, 1969, Hilton Hotel, San Francisco, Calif.

TEMPLE UNIVERSITY HEALTH SCIENCE CENTER presents the 13th Annual Postgraduate Course, Recent Advances in Medicine, on 8 consecutive Wednesdays from October 15th to December 3rd, 1969, from 11:00 a.m. to 4:00 p.m.

Aims of Course: Problems in Clinical Practice

Methods: Grand Rounds, Clinics, Case Discussions, Office Procedures, Lectures and Panel Discussions, all with audience participation.

Faculty: Members of the Department of Medicine and other selected Departments of Temple University Health Sciences Center: guest faculty:

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Dr. David Kipnis, Washington University, St. Louis
Dr. Kurt Isselbacher, Harvard Medical School, Massachusetts General Hospital
Dr. David P. Lauler, Harvard Medical School, Peter Bent Brigham Hospital.
Dr. Carroll M. Leevy, New Jersey College of Medicine
Dr. Robert E. Olson, St. Louis University

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Temple University Health Sciences Center
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Emergency Room physicians needed for full-time staffing. Ideal for the new graduate or for the experienced physician wishing to slow down. Write ADMINISTRATOR, Sharon General Hospital, Sharon, Pa.

General practitioner and general surgeon needed. Fully accredited forty-four bed hospital with plans for expansion in 1969. General practitioners urgently needed in adjacent communities, close to hospital. Somerset County considered the Roof Garden of Pennsylvania. Excellent hunting, fishing, summer and winter sports. Apply to administrator, Meyersdale Community Hospital, Meyersdale, Pa. 15552.

Urologist needed for growing community, with 300-bed hospital. Write Administrator, Sharon General Hospital, Sharon, Pa. 16146.

Ophthalmologist—Board certified or eligible, for active three-man medical and surgical practice in Philadelphia, Pa. Please send curriculum vitae. Applicant must have completed military obligation. Write Department 554, PENNSYLVANIA MEDICINE.

House Physician wanted: Pennsylvania license for 100-bed general hospital, suburban Philadelphia. Immediate opening, salary negotiable. Contact Administrator, Haverford Hospital, Havertown, Pa. 19083.

Pennsylvania-licensed physicians to cover out-patient emergency service in 274-bed accredited general hospital. Write: Office of Administrator, Lower Bucks Hospital, Bristol, Pa. 19007.

Pennsylvania-licensed physicians for group practice in the emergency room. For further information write: Office of the Administrator, Lower Bucks Hospital, Bristol, Pa. 19007.

Wanted: Internists (General Medicine) for a 765-bed GM&S hospital and 550-bed domiciliary, affiliated with George Washington University. Low-cost housing and excellent recreational facilities available. Within easy driving distance of Washington, D. C. and Baltimore, Md. An equal opportunity employer. Apply: Chief of Staff, VA Center, Martinsburg, West Virginia 25401.

Emergency Room Physicians. Membership in group practice. Guaranteed minimum income $30,000. Include complete curriculum vitae in reply. Address to Haluk Boneval, M.D., Chief, Emergency Room Service, Prince George's General Hospital, Cheverly, Maryland 20785. Telephone (301) 341-3041.

Wanted: General Practitioner for a large general and hospital practice in Western Pennsylvania. Gross income $4,500 per month. Investigation invited. Write Department 555, PENNSYLVANIA MEDICINE.

Office space for rent; three rooms, 400 square feet; air-conditioned; reasonable rent; centrally located in small town on fringe of Poconos; previous resident recently deceased while conducting long-established general practice. Contact: Frank J. Parano, 22 West Catawissa Street, Nesquehoning, Pa. 18240. Telephone (717) 669-6087.

Wanted—Doctors who will take their own advice and go to Host Farm for a few days to rest, relax, play golf. Write for a free prescription to: HOST FARM RESORT MOTEL, 2300 Lincoln Highway East, Lancaster, Pa. 17602. Telephone (717) 397-7631.

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Harrisburg office available December 1, 1969. Potential income excellent. Office consists of large waiting room, consultation room, four treatment rooms with equipment. All air-conditioned. Write Department 556, PENNSYLVANIA MEDICINE.

FOR RENT

Ocean City, New Jersey, new two and three bedroom beach-front apartments for rent. Call Philadelphia, 1-215-GA 5-8343.

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WORD COUNT—Count as one word all single words, two initials of a name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one, and "Write Department . . ., Pennsylvania Medicine," as five.

Commentary on Record Keeping

The continued harassment of the practicing physician by required activities related to his profession, but not specifically related to the care of his patients, is a problem to all of us. We must attend staff meetings, committee meetings and organized medicine meetings. In addition to these required activities, the imposition of record keeping in the office and in the hospital often seems to be "the straw that breaks the camel's back."

It is unfortunate that record keeping is the most unpleasant of all the professional activities. It is an essential part of the practice of medicine from several standpoints. As malpractice insurance becomes more difficult to get because of the increasing number of suits against physicians, it should be apparent to all of us that better records, both in the hospital and in the office, would enable us to win a larger percentage of malpractice suits. This, in turn, would keep more casualty insurance carriers interested in the malpractice insurance field.

As third-party payments assume an ever-increasing importance in the financial part of our practice, we must realize that claims managers have a right to look at our records. Their interest in doing so makes it imperative that these records truly mirror what the patient's problem was and what our solution to the problem was.

Finally, insurance review committees find it increasingly obvious that many cases turned down for payment of the hospital bill by Blue Cros or questioned for the size of fee by major medical carriers or Medicare, would never come before the committee if the physician had made certain that the hospital record adequately mirrored his activities with and for that patient. It is not too much to suggest that a physician should make a progress note every time he sees the patient. This serves the purpose of proving that he did make the visit, and assures the carrier that the services charged for were rendered. In addition, the writing of an adequate, clear admission note as to what was the problem facing you and your patient for which you admitted the patient would surely diminish by a significant percentage the number of patients whose bills for hospital services are questioned by or rejected by Blue Cross.

J. Eugene Ruben, M.D., Chairman
Insurance Review Committee
Philadelphia County Medical Society
Reprinted from *Philadelphia Medicine*

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NEXT MONTH!

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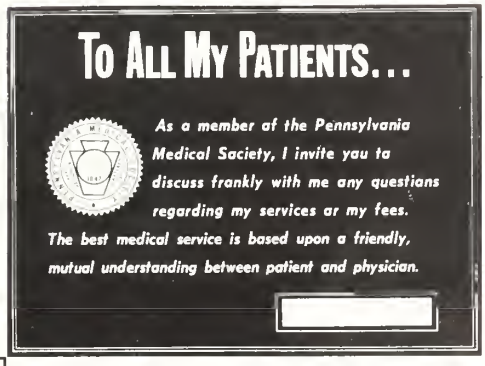

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The PMS Council on Public Service has devised a free message, suitable for framing, for state society members. It is similar to the copy on the plaque sold by the AMA, inviting patients to discuss frankly any questions regarding the physician's services or fees. The message points out that "The best medical service is based on a friendly, mutual understanding between doctor and patient." It will be available as a tear-out sheet on this page, ready for a standard 8 in. x 10 in. frame.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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SEPTEMBER, 1969

D. LECHNER RESIGNS PMS POST; SPECIAL ELECTION PLANNED

William A. Limberger, M.D., chairman of the PMS Board of Trustees and Councilors, has stated that the Board has received the resignation of Carl B. Lechner, M.D., Erie, as president of the State Society, effective at a date yet to be determined. Tentative plans call for a special election of a new president and president-elect by the House of Delegates when it meets in Annual Session in Philadelphia next month. Dr. Lechner's resignation is based on his assumption that he will be unable to fulfill the requirements of office due to prolonged illness.

M'S, OSTEOPATHS TO SPONSOR CONTINUING EDUCATION PROGRAM; JOIN IN PUBLIC RELATIONS VENTURE

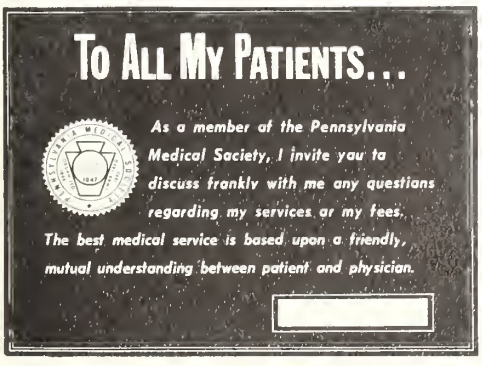
In a continuing effort to bring medicine and osteopathy closer together, the PMS Board of Trustees and Councilors has approved a jointly sponsored, one-day continuing education program for family physicians in Harrisburg in the Fall, 1969. In the area of public relations, the two professions jointly will sponsor a radio documentary program on the subject of athletic injuries.

MERGENCY MEDICAL SERVICES OMMISSION AUTHORIZED

At the recommendation of the PMS Council on Education and Science, the Board of Trustees and Councilors of the State Society has authorized the formation of a nine-member Commission on Emergency Medical Services which will operate as a unit of the Council.

LECTION CALENDAR REMINDER

The Pennsylvania Medical Political Action Committee (PaMPAC) has provided the following election calendar of important dates as a reminder to Journal readers: September 15--Last day to notify county boards of elections of change of residency from one district to another in the county (except Philadelphia); Last day to register before municipal election; First day before municipal election to apply for absentee ballots; Last day to file nomination certificates to fill vacancies for municipal offices.

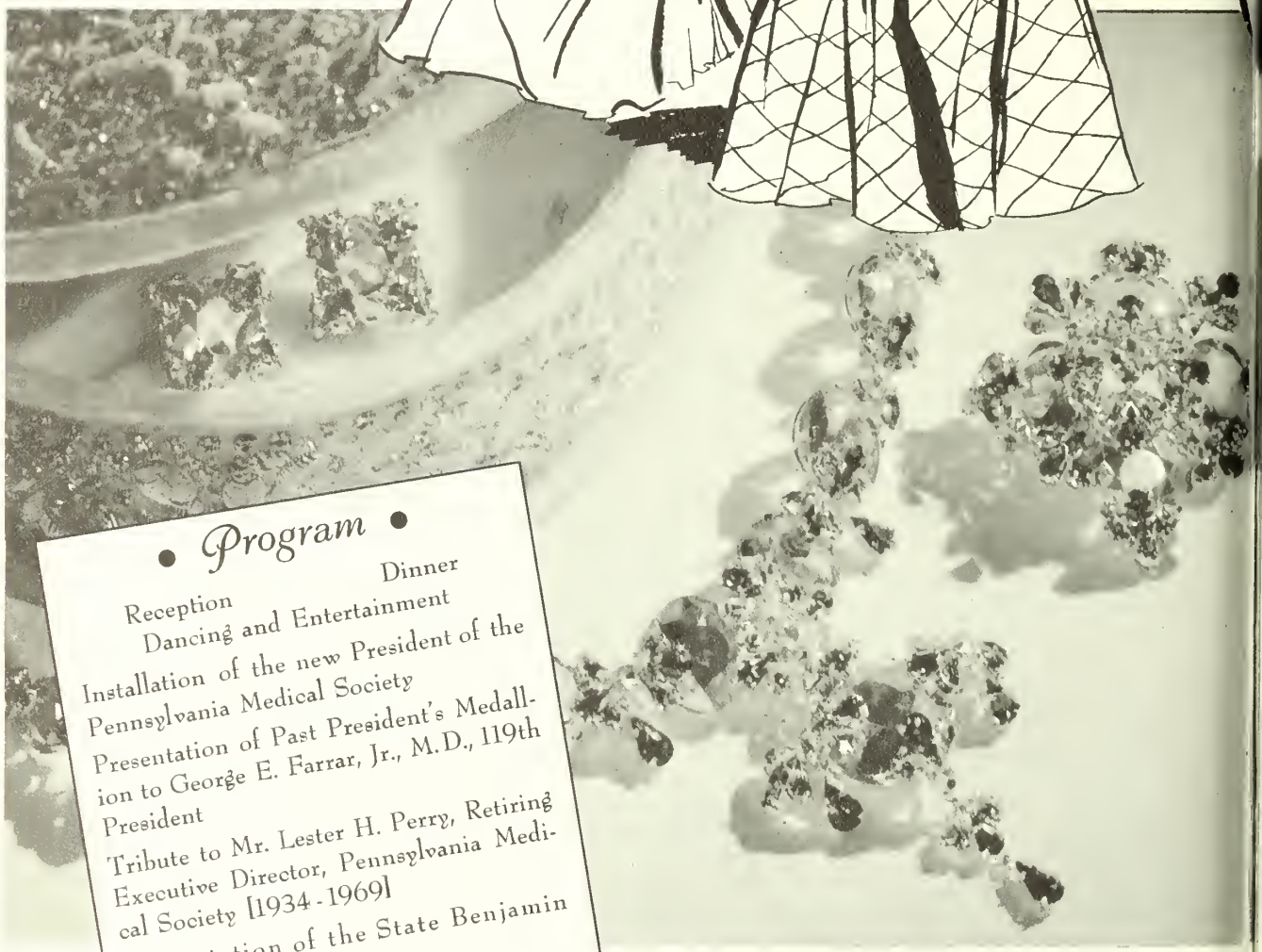


DOCTOR'S OFFICE MESSAGE IN THIS ISSUE

Just a reminder--the inside back cover of this issue of PENNSYLVANIA MEDICINE features an attractive Doctor's Office Message inviting your patients to discuss frankly any questions regarding your services and fees. The message is easily removed and suitable for immediate 8x10 inch framing for your waiting room wall.

22nd Annual
STATE DINNER

FRIDAY EVENING
OCTOBER 10, 1969



• *Program* •

Reception
Dinner
Dancing and Entertainment
Installation of the new President of the Pennsylvania Medical Society
Presentation of Past President's Medallion to George E. Farrar, Jr., M.D., 119th President
Tribute to Mr. Lester H. Perry, Retiring Executive Director, Pennsylvania Medical Society [1934-1969]
Presentation of the State Benjamin Rush Awards

PHILADELPHIA MARRIC
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Please reserve ____ tickets at $12.00 per person for the Reception and Annual State Dinner Dance.

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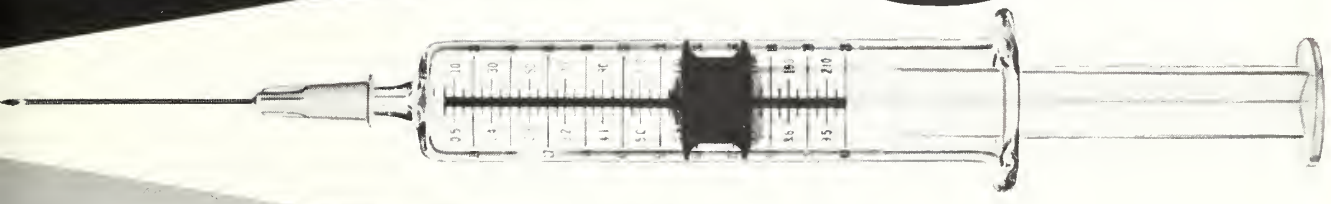

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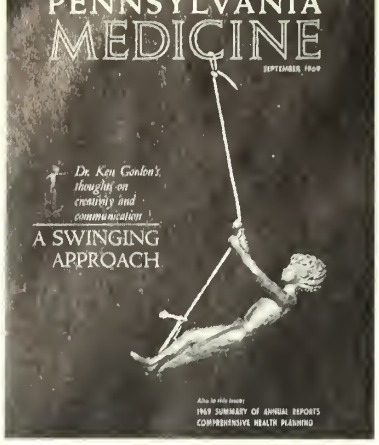

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PENNSYLVANIA MEDICINE

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JOURNAL OF THE PENNSYLVANIA MEDICAL SOCIETY

SEPTEMBER 1969 VOLUME 72 NUMBER 9

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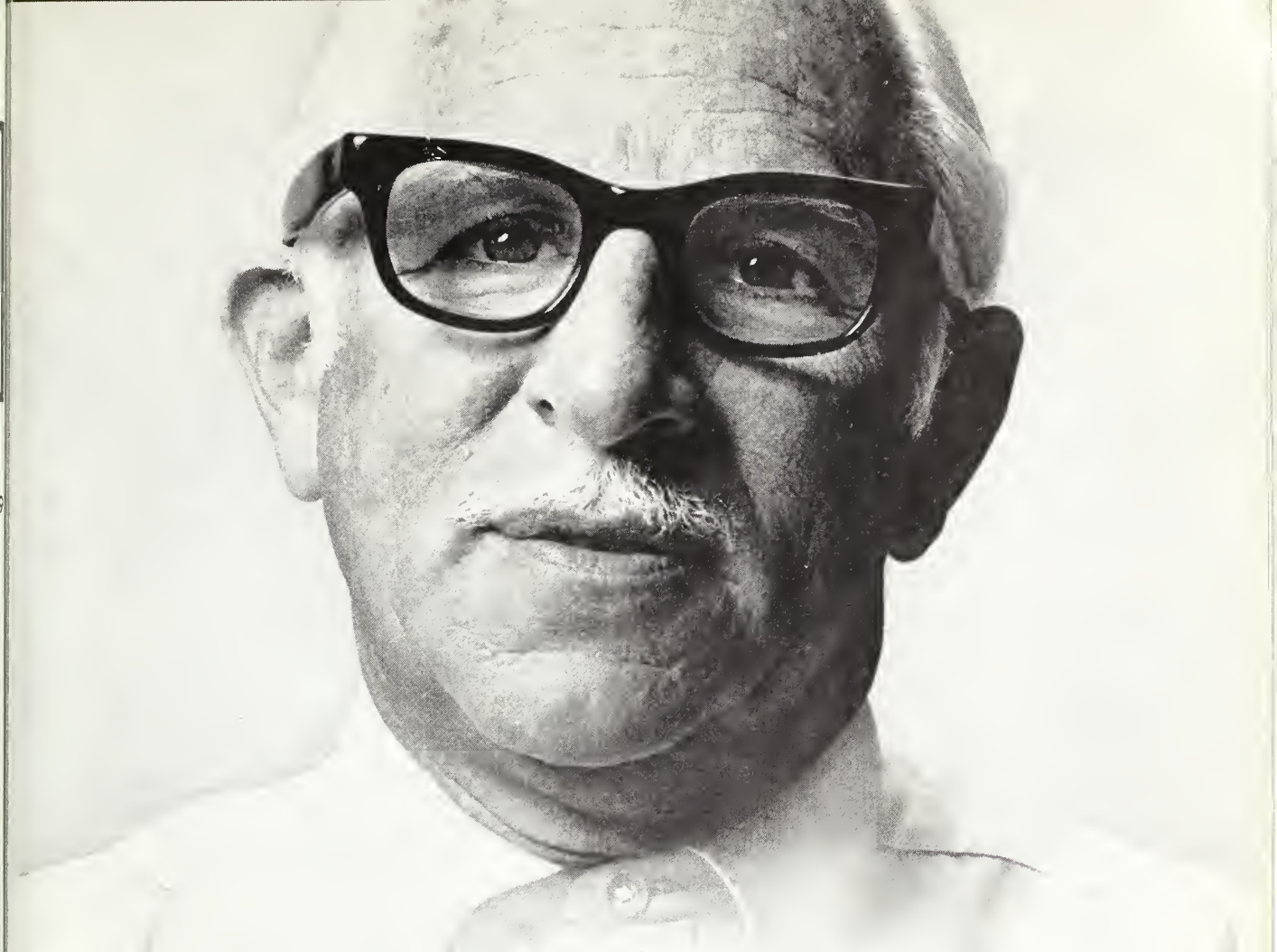

He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

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o guard susceptible patients against intestinal monilial over-owth during broad-spectrum therapy—the protection of ystatin is combined with demethylchlortetracycline in ECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN the broad-spectrum therapy that prevents monilial vergrowth.

ffectiveness: Because its antibacterial component is DECLOMYCIN emethylchlortetracycline, DECLOSTATIN should be equally or more fective therapeutically than other tetracyclines in infections caused by tracycline-sensitive organisms. The antifungal component, Nystatin, otects against superinfection by antibiotic-resistant fungal overgrowth articularly monilia) in the intestinal tract.

ntraindication: History of hypersensitivity to demethylchlortetracy-ine or nystatin.

arning: In renal impairment, usual doses may lead to excessive accum-ation and liver toxicity. Under such conditions, lower than usual doses e indicated, and, if therapy is prolonged, serum level determinations ay be advisable. A photodynamic reaction to natural or artificial sun-ght has been observed. Small amounts of drug and short exposure may oduce an exaggerated sunburn reaction which may range from ery-ema to severe skin manifestations. In a smaller proportion, photo-llergic reactions have been reported. Patients should avoid direct posure to sunlight and discontinue drug at the first evidence of skin scomfort. Necessary subsequent courses of treatment with tetracy-ines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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when it's late in life and anxiety and depression coexist...

initial therapy

Triavil® 4-10

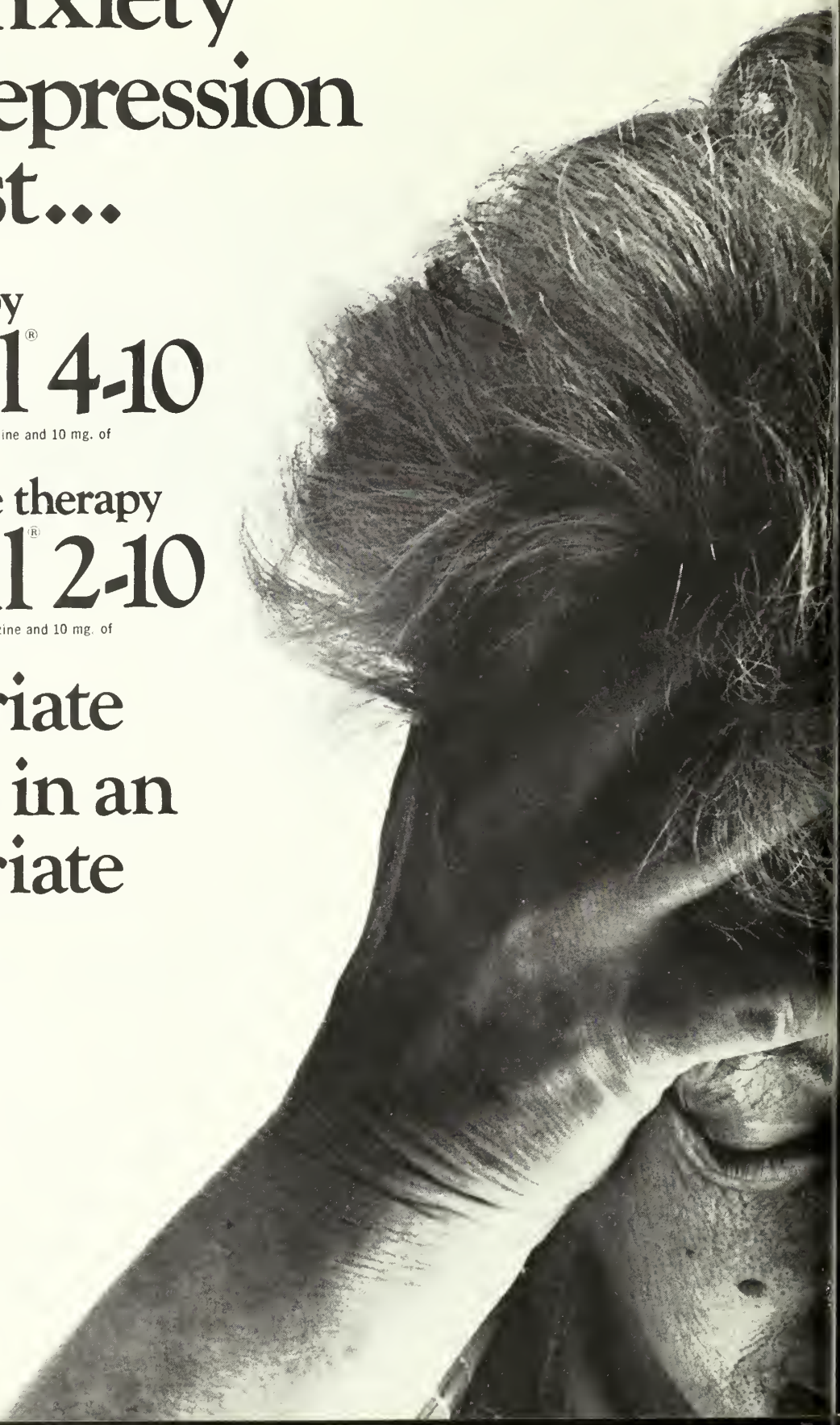
Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride

maintenance therapy

Triavil® 2-10

Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

appropriate therapy in an appropriate dosage



During the years of declining strength and increasing infirmity, many patients are more sensitive to both the desired response and the unwanted effects of some drugs. That's when low-dosage therapy is needed. And that's when TRIAVIL 4-10, as initial therapy, and TRIAVIL 2-10, for maintenance, can prove particularly useful.

Starting with TRIAVIL 4-10 should help minimize possible dose-related side effects in the geriatric patient with coexisting anxiety and depression. And, subsequently, TRIAVIL 2-10 can increase flexibility in adjusting maintenance dosage.

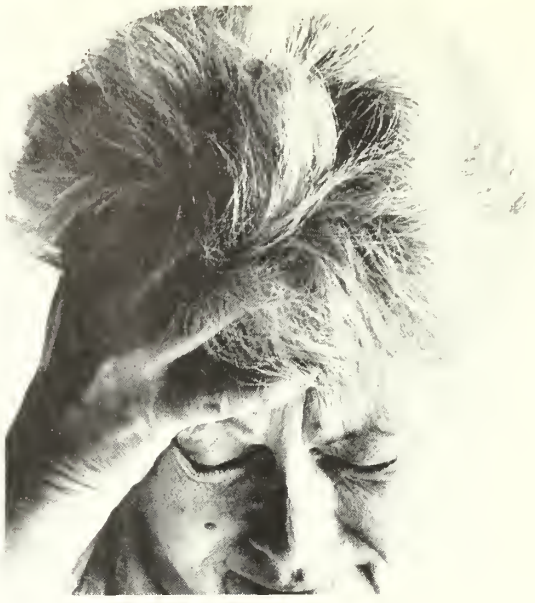
Activities made hazardous by diminished alertness should be avoided. You will want to inform your patients that the effects of alcohol may be potentiated. Because of the potentiation of other drug effects possible with MAO inhibitors, such agents should not be given concomitantly with TRIAVIL. However, therapy with TRIAVIL can be initiated cautiously two weeks or more after withdrawal of the MAOI drugs. And, until significant remission is observed, close supervision of any seriously depressed patient is, of course, essential to guard against possible suicide. The drug is contraindicated in glaucoma, in patients expected to experience problems of urinary retention, in drug-induced CNS depression, and in bone marrow depression.

TRIAVIL 4-10 & 2-10—tranquilizer-antidepressant therapy especially appropriate for the elderly patient so often intolerant to medication in high dosages.

TRIAVIL® **for moderate to severe anxiety with coexisting depression**

containing perphenazine and amitriptyline HCl
TRANQUILIZER-ANTIDEPRESSANT

For additional prescribing information, please see following page.



TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

TRIAVIL 4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.
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TRIAVIL 4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.
TRIAVIL 2-10: For use in adjusting maintenance dosage. Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

for moderate to severe anxiety with coexisting depression

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory reponse.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone. **Perphenazine:** Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe, acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides. **Amitriptyline:** Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Before prescribing or administering, read product circular with package or available on request.

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where today's theory is tomorrow's therapy

newsfronts

Appalachia Visitors

Two medical students *who worked this summer in the Student American Medical Association Appalachia preceptorship program visited PMS headquarters recently with the doctors under whom they have been working. Shown above are, standing, left to right, D. Ernest Witt, M.D., Bloomsburg, and George A. Rowland, M.D., Millville. Seated, using equipment of the Council on Public Service, are medical students from Wayne State University Medical School, Detroit, Mich. They are, left to right, Dorothy Kelly of Fitchburg, Mass., a second year student, and David Sperry of Waltham, N.Y., also in his second year of medical school. Both medical and nursing students from all over the country participated in the SAMA Appalachia program, to learn the needs of rural America for health care and to identify with the rural physician. The program was endorsed by the Pennsylvania Medical Society.*

Action Urged on Chiropractic Measure

The Council on Governmental Relations has informed component societies and their officers that Senate Bill 254, which would place chiropractic services in Blue Shield coverage, has passed the State Senate, and has been referred to the House Committee on Public Health and Welfare. The Council urges all members of the State Society to contact members of this committee, urging them not to act favorably on S-254, since there are many important services which Blue Shield should cover prior to adding this.

Members of the House Committee on Public Health and Welfare, and their counties, are as follows. All may be addressed in care of the House Post Office, Harrisburg, Pa. 17120: Sarah A. Anderson, Philadelphia, chairman; Anita P. Kelly, Philadelphia, vice-chairman; Russell J. Blair, Fayette; Gerald Kaufman, Allegheny; Frank W. O'Brien, Allegheny; James Musto, Luzerne; German Quiles, Philadelphia; James J. Tayoun, Philadelphia; James D. Barber, Philadelphia; Norman S. Berson, Philadelphia; Milton Berkes, Bucks; Theodore Johnson, Allegheny; Andrew J. McGraw, Allegheny; Bernard F. O'Brien, Luzerne; William H. Claypoole, Armstrong; Patricia A. Crawford, Chester; Eugene M. Fulmer, Centre; Sherman L. Hill, Lancaster; Richard A. McClatchey, Jr., Montgomery; Andrew S. Moscrip, Bradford; Charles F. Mebus, Montgomery; H. Sheldon Parker, Jr., Allegheny and Francis Worley, Adams.

RMP Rings In Data-phone Link

Physicians all over central Pennsylvania and New York will soon be able to keep up to date with the latest in medical advances merely by picking up the telephone.

Under a new project sponsored by the Central New York Regional Medical Program five-minute lectures of "core" information on about 500 different medical subjects will be available to physicians by dialing a toll-free telephone number and requesting the program they wish to hear.

One of fifty-five such programs throughout the country working to improve care of patients with heart disease, cancer, stoke and related conditions, it acts locally as a coordinator and clearing house for projects initiated by various community groups.

The dial access project will be funded by a one-year grant of $21,-223 taken from funds not expended in 1968-1969. It has been approved by the U.S. Public Health Service Division of Regional Medical Programs.

The dial access project will be headquartered at the Robert Packer Hospital in Sayre, Pa.

In addition to the areas covered in central New York dial access will be available to physicians in these Pennsylvania counties: Bradford, Susquehanna, Tioga, Lycoming, Sullivan, Wayne, Pike, Lackawanna, Luzerne, Union, Montour, Columbia and Clinton.

The area has a population of approximately 2.7 million people, of which 3,200 are physicians. The geographic dimensions are approximately 270 by 100 miles.

In addition to the brief medical lectures, each month a review of current literature on heart disease, cancer and stroke, RMP's main targets, will be available over the telephone. Following each tape, the physician will be given the opportunity to request photostats of any articles which interest him.

newsfronts

Surgeons To Study Highway Crash Emergency Care

Improved in-hospital emergency treatment of highway crash victims is the aim of a new educational program to be launched by the American College of Surgeons with financial assistance from the Insurance Institute for Highway Safety.

William Haddon, Jr., M.D. institute president, announced that a $15,000 grant had been made to enable the college's committee on trauma to undertake the program. The college is matching this amount and also will seek additional funding to expand the program.

Beginning with three eight-week educational projects for physicians to be conducted by members of the college of surgeons in several parts of the country in rural areas, the program will be expanded nationwide. A majority of deaths from highway injuries result from crashes occurring far from urban medical centers.

"As physicians and surgeons know, emergency medical care needs, whether on-site or in the hospital, have too long been neglected by the highway safety movement," said Dr. Haddon. "It is gratifying that the college of surgeons is taking this step to improve the treatment of the injured."

In accepting the institute grant, John Paul North, M.D. director of the college, said: "The committee is conducting nationwide educational activities to improve the immediate care and transportation of the injured before they reach hospitals. The college now wants to broaden its trauma program by including emphasis on the closely related in-hospital emergency treatment of the injured.

"At this time there is no organized, comprehensive program of continuing medical education for physicians in emergency life-saving measures for critically injured highway crash victims. Particularly no program exists to provide such education for physicians in their home communities and in the environment of the hospitals in which they practice."

Heart-Lung Machine Tribute

Abraham E. Rakoff, M.D., *left, professor of obstetrics and gynecology and medicine and president of the Alumni Association of Jefferson Medical College, presents to John H. Gibbon, Jr., M.D., right, emeritus Samuel D. Gross professor of surgery, Jefferson Medical College, a plaque commemorating the development, through twenty years of research, of a successful heart lung machine by Dr. Gibbon. The plaque was presented by Dr. Rakoff at a luncheon given by Jefferson Dean William F. Kellow, M.D. The bronze plaque is to be placed in the lobby of Jefferson Medical Center as a permanent commemoration of the historic event in heart surgery.*

Councilor District Meetings Set

Nine PMS Councilor Districts have scheduled meetings from 3:00 p.m. to 5:00 p.m., October 9, 1969, during the 120th Annual Session of the Pennsylvania Medical Society at the Marriott Motor Hotel, Philadelphia.

The councilor of each district extends a cordial invitation to all members of the county medical societies in his district to attend.

At these meetings, physicians will have an opportunity to discuss matters of importance that will be brought before the PMS House of Delegates, as well as other pertinent Councilor District business.

Meetings scheduled are as follows: District 2—Delaware Ballroom, Salon 1; District 4—Delaware Ballroom, Salon 2; District 5—Brandywine Ballroom, Salon A; District 6—Brandywine Ballroom, Salon B; District 7—Brandywine Ballroom, Salon C; District 8—Pennsbury Room-East; District 9—Pennsbury Room-West; District 11—Fairmount Room-East and District 12—Fairmount Room-West.

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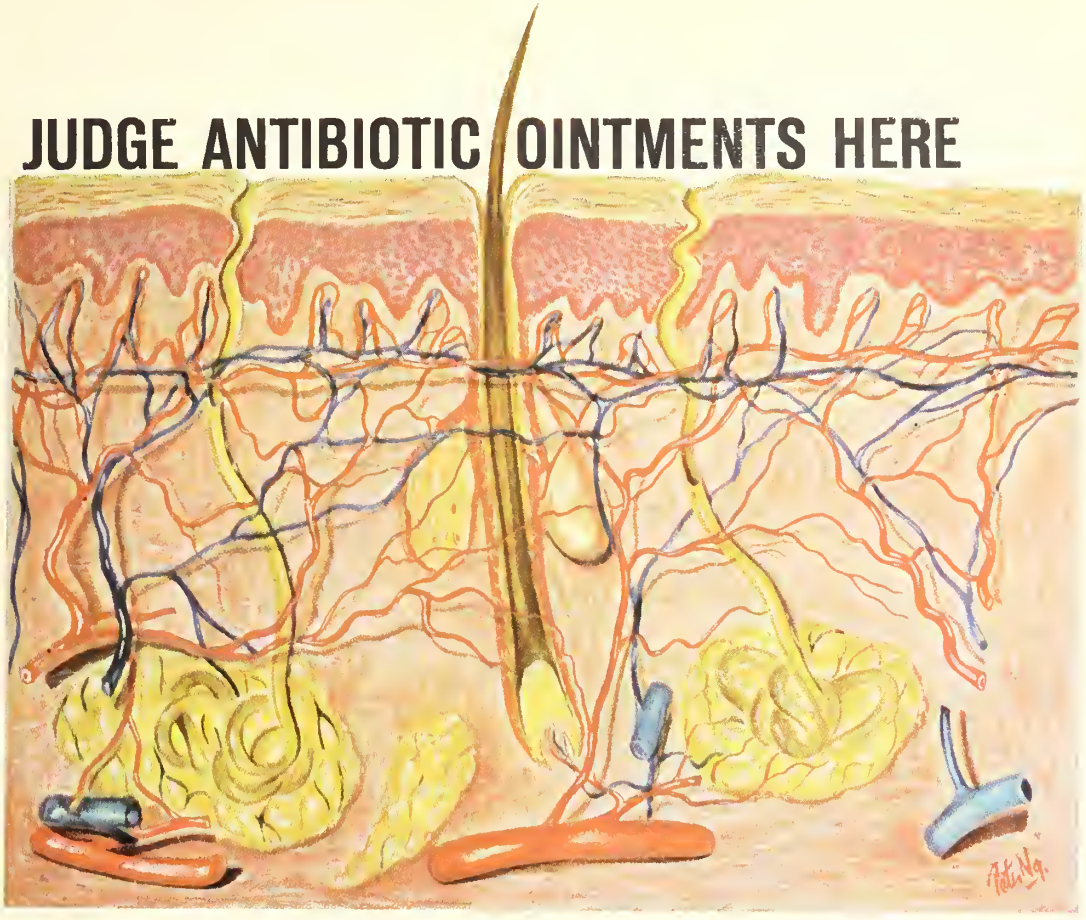

Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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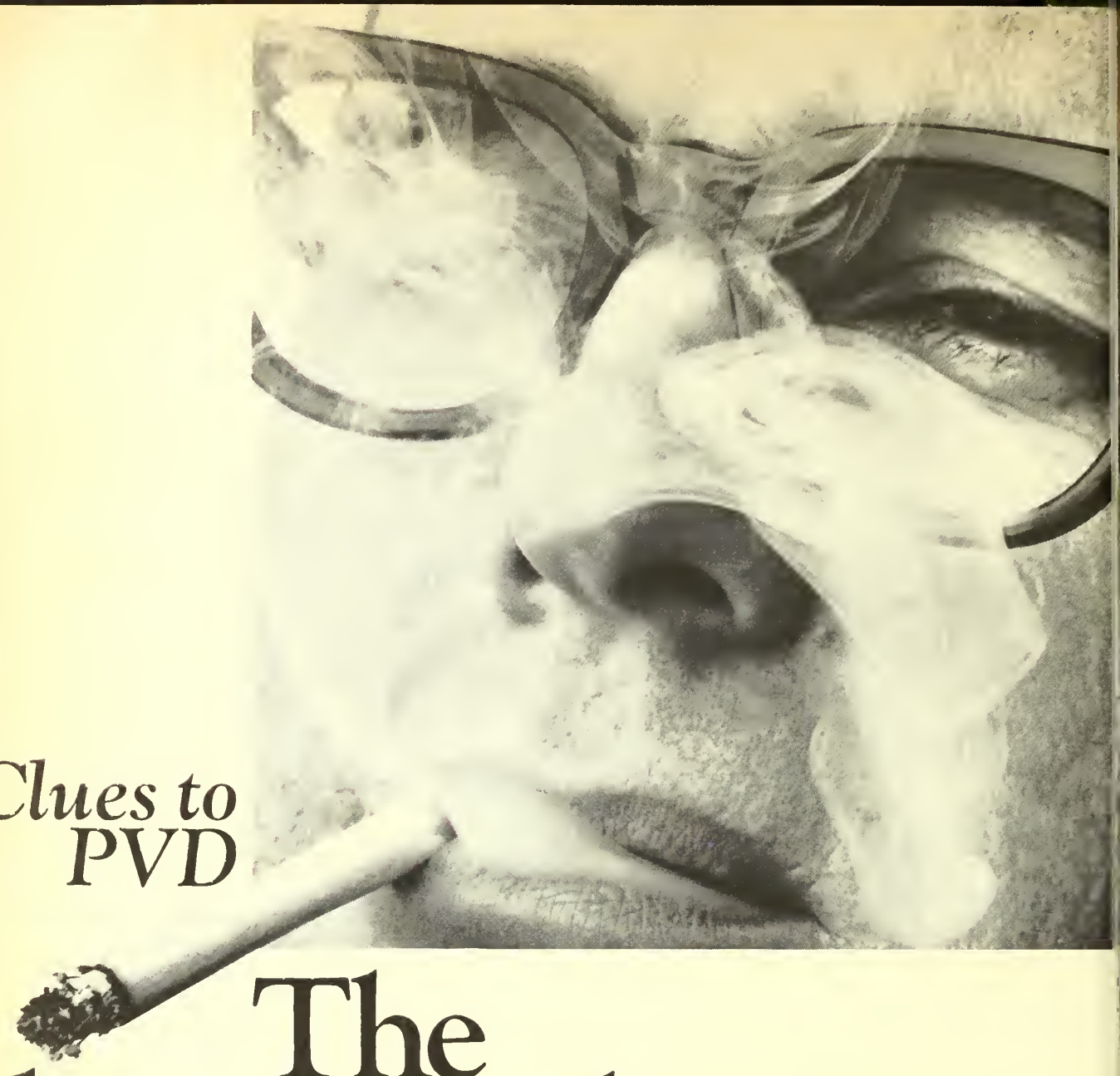

Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; e.g., peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets - 150 mg nicotinyl alcohol in the form of the tartrate salt —bottles of 50.

Roche
LABORATORIES
Division of Hoffmann-LaRoche Inc.
Nutley, New Jersey 07110

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.

Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability and agitated prepsychotic states. Do not use with other CNS stimulants including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general these cases were characterized by excessive consumption of the drug for its central stimulant effect and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

Pink, round Endurets® prolonged action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B)R3-46-560-B

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Boehringer
Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

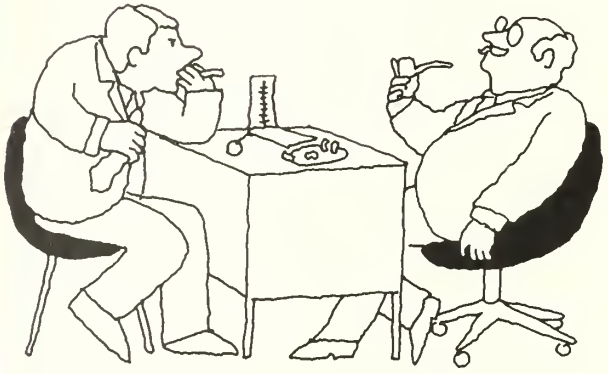
A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

Preludin® phenmetrazine hydrochloride

Endurets® prolonged-action tablets

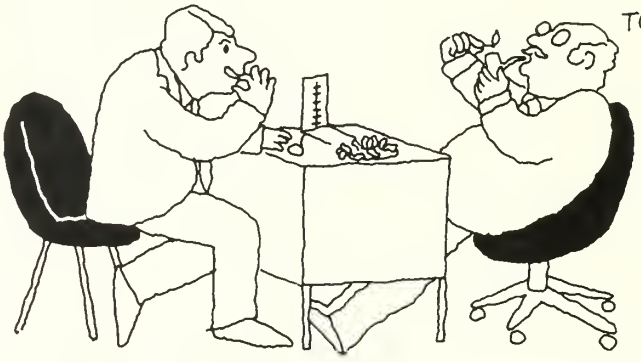
Geigy

The Apprehensive Hypertensive



WELL, YOU HAVE WHAT WE CALL MODERATE HYPERTENSION— HIGH BLOOD PRESSURE. NOW I DON'T WANT YOU TO WORRY, BUT WE ARE GOING TO HAVE TO CHANGE A FEW LIVING HABITS. FIRST, WE'RE GOING TO HAVE TO CUT OUT SMOKING—ALTOGETHER.

THEN WE HAVE TO LOSE WEIGHT. 20 POUNDS SHOULD DO IT... WE'LL TALK A LITTL LATER ABOUT THIS DIET WE'RE GOING TO START.



Regroton® to lower blood pressur

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg. *Indications:* Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia have occur in infants born to reserpine-treated mothers. *Precautions:* Any hypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglion-blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progressive renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy the drug should be discontinued and potassium supplements given provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving

WE'VE GOT TO GET
PLENTY OF REST AND
TRY TO AVOID SITUATIONS
THAT MAKE US ANXIOUS
OR TENSE. AND WE'LL
TAKE MEDICINE TO LOWER
OUR BLOOD PRESSURE
AND CALM US DOWN.

WE'VE GOT
PROBLEMS.

and allay anxiety in hypertension

rticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. *Adverse Reactions:* The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-C

For details, please see complete prescribing information.

Regroton®

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

newsfronts

York Hosp. Strongly Supported by Citizens

"The Greater York Community, through individual, business and corporation pledges contributed $5,113,-050 toward York Hospital's 15.5 million dollar expansion program," Russel G. Gohn, campaign chairman, reported has reported.

This five million dollar plus report is the largest public subscription ever to be achieved in the history of York County.

As a result of the achievement, a five by eight foot flag, inscribed with York Hospital Project '80—Five Million Plus will be flown from the hospital's flagstaff.

Mrs. Charles E. Snyder, representing the 3400-member York Hospital United Auxiliaries Council presented a $50,112.60 York Hospital Fete proceeds check to Marvin G. Sedam, Chairman of the Hospital's Board of Directors. Mrs. Snyder is the president of the board of the Woman's Auxiliary and chairman of the United Auxiliaries Council.

This net profit check fulfills a portion of their half million dollar pledge for the hospital's complete out-patient department, cardio pulmonary function area and the cobalt 60 unit.

"The campaign for five million dollars which began in April was an ambitious project for York and the surrounding communities. Citizens of our communities responded to the need of correcting the overcrowding and overtaxed areas of York Hospital which has been functioning in space that was adequate for yesterday's demands. We have succeeded . . . our millions of thanks to those who saw the need and did something about it," said Mr. Gohn.

Mr. Gohn further cited that the campaign is not over. . . . He emphasized this point by adding, "There are many people as well as business firms and corporations that still want to contribute to the urgently needed program. They will continue to have this opportunity. Every dollar raised over the goal will help reduce the monies that will have to be borrowed, and will help to offset the rapidly rising building costs."

Cancer Award Presented

J. Permar Richards, left, chairman, board of trustees, American Cancer Society, Philadelphia Division, and Philip J. Hodes, M.D., president, ACS, Philadelphia, *present the 1969 Philadelphia Division Award to* **Charles S. Cameron, M.D.,** *president, Hahnemann Medical College and Hospital of Philadelphia. Dr. Cameron was cited by ACS as "healer of the sick, medical pioneer, teacher, author and administrator." Dr. Cameron, who is the author of "The Truth About Cancer" was president of Philadelphia ACS and before becoming dean and then president of Hahnemann was medical and scientific director of ACS in New York.*

Health Task Force Organized

More than 140 Pennsylvanians will be selected in the next two months to serve on the task forces of the state Advisory Council for Comprehensive Health Planning, Peter W. Duncan, council chairman, announced today.

Appointments to the nine task forces are being made by Duncan in consultation with the task force chairmen and acting Secretary of Health Thomas W. Georges, Jr. M.D.

As required by law, the majority of members of each task force will be consumers of health services, such as housewives and businessmen. The other members will be health providers, such as physicians, hospital administrators, therapists and sanitary engineers.

"Members are being selected from suggestions received from approximately 150 organizations, professional societies, civic groups and individuals in the state," Duncan said.

"Appointments will not be honorary positions but will require hard work in assisting the Council's efforts to establish state health priorities," he said.

The task forces are: health costs and financing; health information; health manpower; planning coordination; regional needs and services; environmental health services; personal health services; health facilities; and data collection and retrieval.

Can one prescription do the work of two?

Yes, Kolantyl®.

Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

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Cincinnati, Ohio 45215

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(0715)

State Ragweed Sampling Ordered

The State Health Department's bureau of air pollution control announced plans recently for its ninth annual statewide sampling of the ragweed pollen responsible for hay fever sneezes in the summer breezes.

The survey, which is intended to pinpoint areas with relatively low ragweed pollen concentrations and also areas where ragweed control efforts are needed, is being conducted during August and September by volunteers in forty communities.

In addition to municipalities where the sampling has been carried on previously, new locations for 1969 include Altoona, East Stroudsburg, Punxsutawney and White Haven.

During the two-month survey period, which coincides with the peak of the "hay fever season" in Pennsylvania, daily counts are taken of the ragweed pollen concentration at each of the sampling stations. These daily counts and seasonal totals are combined mathematically to give a "pollen index" for each community.

For purposes of comparison, an index figure greater than ten indicates a need for a ragweed control program. Most communities are above this level.

Past surveys have shown relatively high indices in the western and southeastern areas of the Commonwealth and relatively low indices in northcentral and northeastern areas.

During last year's sampling, the best records for individual stations were turned in by Kane with an index of one, Warren with five and Lewistown with seven. The highest indices were found at Washington with 103, New Castle with 72 and Sharon with 70.

Since past experience has shown that community-wide ragweed control programs can be effective in reducing pollen concentration for an area, the health department is urging the adoption of such programs.

As an indication of the effectiveness of these programs, the department cites the "Bag the Ragweed" contest at Hershey last year during which local youngsters competing for modest prizes collected more than four tons of weeds. More important, the program reduced the community's 1968 total pollen count approximately 30 per cent below 1967. The Hershey program was conducted again this year.

Ragweed can be controlled at this time of year either by cutting the plants low near the roots or by the use of a selective weed-killer such as 2,4-D. The health department warns, however, that weed killers should be used only in accordance with printed instructions for proper application.

Top Resident, Intern Honored

Awards for Excellence—*Bernard J. Ostrum, M.D., (left) chairman of the Intern and Resident Committee at Philadelphia's Albert Einstein Medical Center, presents awards to (center) Jay Handler, M.D., of nearby Roslyn, judged the medical center's top intern of the year by physicians on Dr. Ostrum's committee and by his peers as well in an informal poll, and to M. R. Jayasanker, M.D., fourth-year surgical resident from Madras, India, selected as Einstein's top resident physician. Jayasanker, a graduate of Madras Medical College, interned at Ottawa General Hospital, Ottawa, Canada, before coming to Einstein under the U.S. Department of State Exchange Program four years ago. Handler, a Philadelphia native, is a 1960 graduate of Central High School, a 1964 graduate of Albright College, and a 1968 graduate of the University of Pittsburgh Medical School.*

Drug Survey To Query M.D.'s

The Community Health Research Group of Ohio State University is making a survey and collecting data from practicing physicians to be used in the preparation of accurate and realistic cases involving drug therapy. These cases will be used for the purpose of instruction, as well as in problem-solving seminars.

Physicians throughout Pennsylvania will be asked to provide such data. If further information regarding the project is desired, inquiries may be addressed to: David A. Knapp, Ph.D., Project Director, Community Health Research Group, Ohio State University, 500 W. Twelfth Ave., Columbus, Ohio 43210.

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

Newsfronts

Aerosol Abuse Studied

The Inter-Industry Committee on Aerosol Use formed primarily for the purpose of educating against deliberate misuse of aerosol products adopted a Constitution and Bylaws, elected Trustees, and approved the program of the Aerosol Education Bureau at a recent meeting in New York City. The program sub-committee which directs the activities of the Aerosol Education Bureau will proceed immediately with the development and distribution of informational materials for schools, youth groups, and media reaching young people, as well as to civic officials, public health and police departments, and the press.

The division of pediatrics at Allegheny General Hospital, Pittsburgh, is to become the regional pediatrics center for its district, and has planned a new and expanded health care program for children living in northwestern Allegheny County. The new pediatrics program, which is expected to cost one million dollars, will involve close cooperation with Children's Hospital and the University of Pittsburgh School of Medicine. It is designed to avoid needless duplication of services, to cut costs, and to expedite the delivery of health care to children.

International Guest Speaker

Speaking to a Montour County Medical Society's meeting *recently was Donato Alarcón-Segovia, M.D. right, head of the immunology laboratory and consultant in rheumatology at the National Institute of Nutrition, Mexico City, Mexico. Dr. Alarcón-Segovia appeared in conjunction with a two-day meeting of specialists in arthritis and related diseases, held at Geisinger Medical Center. The visiting physician's lecture before the Medical Society concerned the ability of certain drugs to activate systemic lupus erythematosus, a serious disease which often affects the joints as well as other body organs. He indicated that some drugs used in the treatment of hypertension, tuberculosis, epilepsy and disorders dealing with heart rhythm can activate the disease. Robert C. Eyerly, M.D., president of the society, presided and Randolph C. Blodgett, Jr., M.D., rheumatologist at the center, at left above, introduced the guest speaker.*

State Births, Deaths Decrease Says Report; Heart Disease, Cancer Leading Causes

It's official. There were fewer deaths among Pennsylvanians in 1967 than there were in 1966, and there were also fewer live births in the State.

In actual numbers, 125,494 Pennsylvania residents died in 1967, compared with 126,820 in 1966; and there were 188,706 live births compared with 195,869.

These official 1967 statistics, which confirmed the trends of earlier unofficial estimates for the year, were released recently in the State Health Department's annual report on natality and mortality.

According to the report, 1967 was the tenth consecutive year to reflect a decrease in the State's rate for live births, and the rate of 16.2 per 1,000 estimated midyear population represented a decrease of 29 per cent under the high 1957 rate of 22.8 per thousand. The average rate for the 1958-1967 period was 19.6 per thousand.

The leading cause of death among Pennsylvania residents during 1967 was heart disease, which accounted for 53,121 or 42.3 per cent of the total. The second most frequent cause was cancer, with 21,450 deaths; and the third was vascular lesions affecting the central nervous system (apoplexy, cerebral hemorrhage, stroke, etc.) with 12,295. Together, these three conditions accounted for 69.2 per cent of the total deaths.

Statistical material in the report is presented in tables for the state as a whole and for individual counties and selected cities. Included in the tables are a variety of data most frequently requested by persons having a special interest in health, welfare, medical, educational, planning and industrial health programs.

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(diphenhydramine hydrochloride)

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now he can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

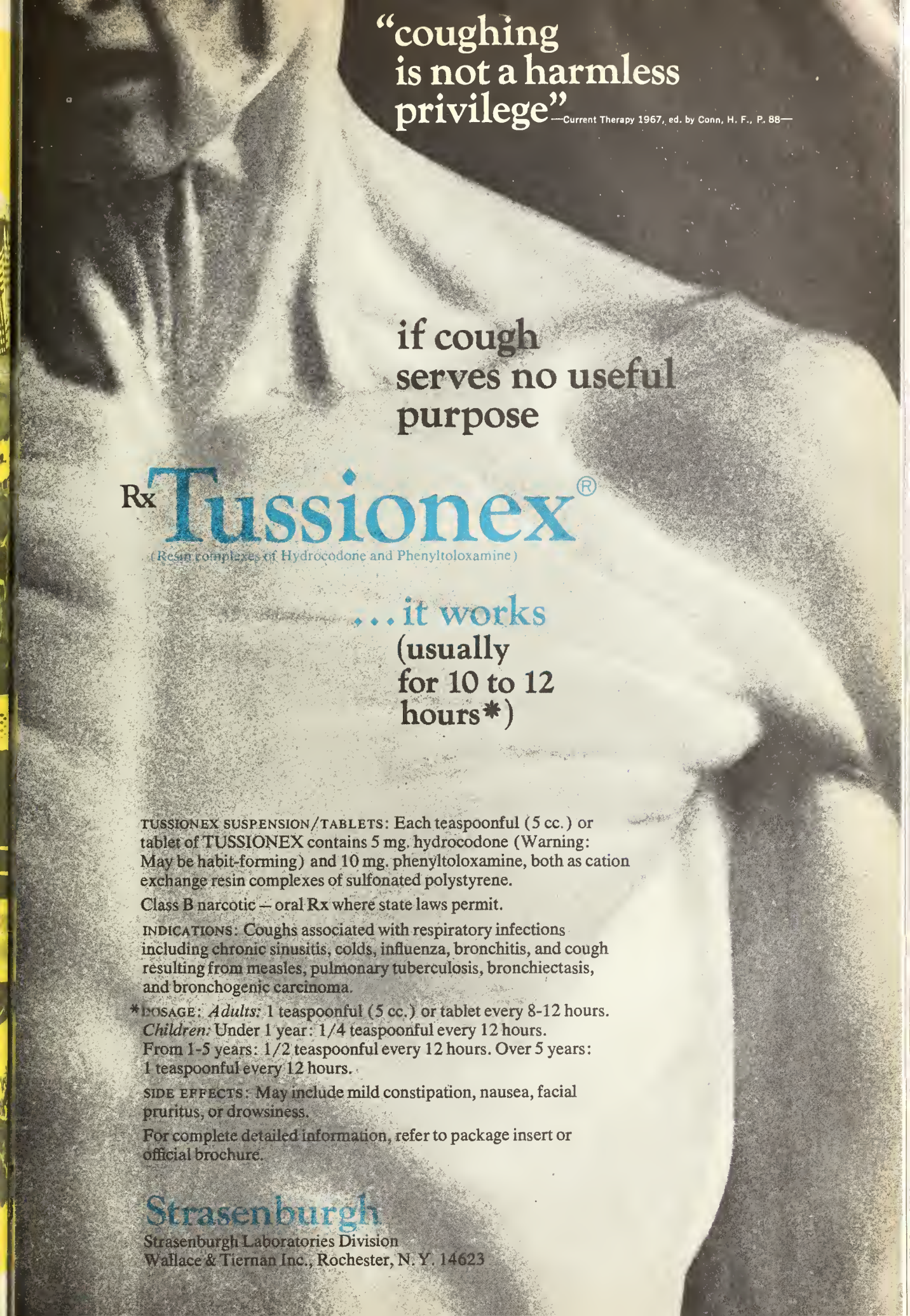
Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.


"coughing is not a harmless privilege"—Current Therapy 1967, ed. by Conn, H. F., P. 88—
if cough serves no useful purpose
Rx Tussionex®
(Resin complexes of Hydrocodone and Phenyltoloxamine)
...it works (usually for 10 to 12 hours*)
TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.
Class B narcotic – oral Rx where state laws permit.
INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.
*DOSAGE: Adults: 1 teaspoonful (5 cc.) or tablet every 8-12 hours. Children: Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.
SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.
For complete detailed information, refer to package insert or official brochure.
Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623

No place for beginners

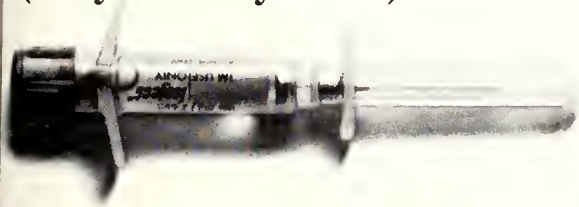
Terramycin®
(oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Pfizer **LABORATORIES DIVISION**
New York, N. Y. 10017

Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc. Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request.

A procedure *for the measurement of physical work capacity which, in this instance, is measured by assessment of aerobic capacity or the maximal oxygen intake which is directly related to the delivery of oxygen to working muscle.*

M.D.'s, Researchers Discuss

Helping the athlete achieve an excellence of performance in the safest and best managed environment was the foundation of a unique first meeting co-sponsored by the Pennsylvania Medical Society and the Pennsylvania State University at State College in June.

The Conference on Practical Application of Physiological Principles to Medicine in Athletics was attended by more than twenty participants of varied medical, osteopathic and athletic interests.

The purpose of the one-day session was to present current information and concepts concerning the physiology of physical performances and to provide pertinent physiological demonstrations to physicians involved with management of the health of athletes and to athletic team physicians who are working with athletes from junior high school age to professional age.

Among the areas covered in the program were: physical conditioning —some general principles and methods of assessment; cardiopulmonary response to strenuous exercise; nutrition of the athlete—the glycogen story, and the environment and athletics.

Conferees observed demonstrations on assessment of aerobic capacity, heat strain assessment and electromyography.

In commenting on the purpose of the conference in his opening remarks to the gathering, William C. Grasley, M.D., Penn State team physician, indicated a strong need for communication between the researcher in sports medicine and the man on the playing field—the physician taking care of the athlete.

"Between the physician and the researcher, there has to be some way for us to learn what is being done, why it's being done, how it's being done—and most of all to make the work worthwhile by getting the results of the cooperative efforts of research and the physician to the athlete," said Dr. Grasley.

Speakers on the program included Dr. Grasley, James S. Skinner, Ph.D., assistant professor of applied physiology; James Kollias, Ph.D., associate

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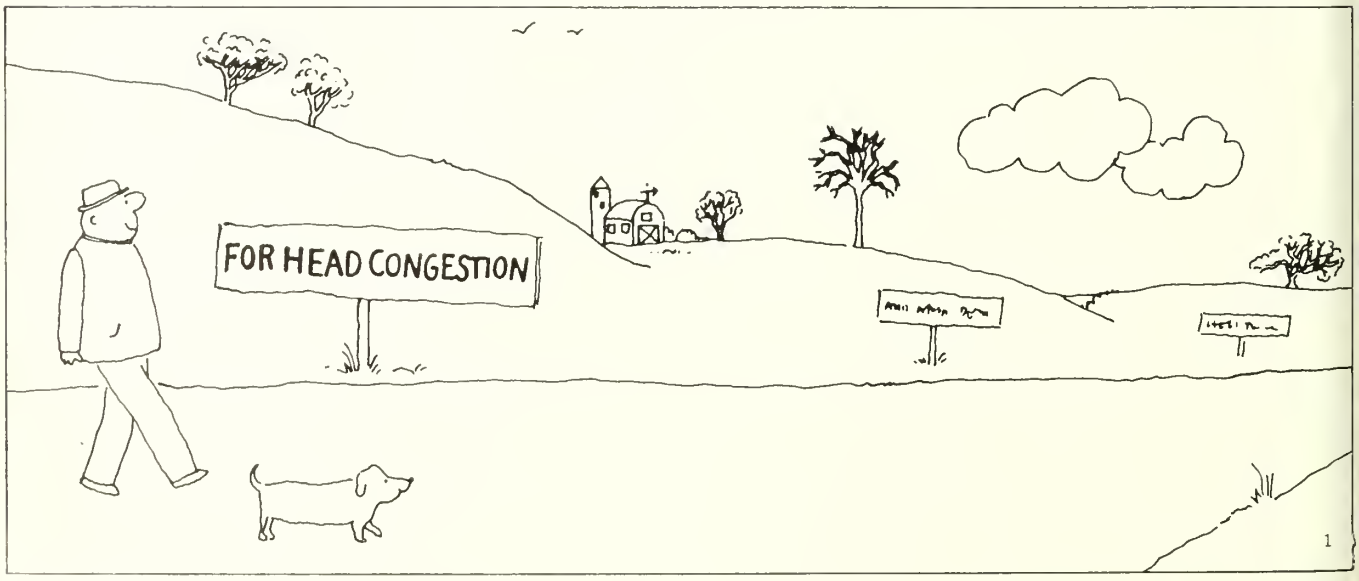

Medicine in Athletics

professor of applied physiology; Elsworth R. Buskirk, Ph.D., professor of applied physiology and director, laboratory for human performance research; Oded Bar-Or, M.D., assistant professor of applied physiology; Joseph L. Loomis, instrumentation engineer; W. Channing Nicholas, M.D., associate professor of applied physiology; Paavo Komi, doctoral candidate; Jose Mendez, Ph.D., professor of applied physiology; and Rodney A. Rhoades, Ph.D., assistant professor of applied physiology—all of the faculty of the Pennsylvania State University.

Guest participants included Ramon C. Burket, M.D., football team physician, Central High School, Martinsburg; K. M. Coffman, M.D., team physician, Montoursville Junior High School; Robert B. Edmiston, M.D., school physician, Central Dauphin Joint Schools and chairman, PMS Commission on School Health, Harrisburg; Samuel B. Fleagle, M.D., Penn State University; John J. Hanlon, M.D., school and sports doctor, Mechanicsburg Senior and Junior High School; Albert Henderson, M.D., school and athletic physician, Susquehannock High School, Glen Rock; David Hinchberger, athletic coach and health instructor, West Shore School District, Camp Hill; Victor Liscinsky, head trainer and physical therapist, Clarion State College; William C. McNeal, D.O., Philadelphia College; David G. Moyer, M.D., medical director, Germantown Academy; Gordon D. Myers, M.D., director, emergency room and surgeon, Harrisburg Hospital; James I. Nixon, M.D., team physician, Philadelphia Eagles, Philadelphia; C. J. Poolos, M.D., internist, Greenville Medical Center Clinic; Robert L. Roberts, M.D., sports program physician, Spring Grove Area Junior and Senior High Schools; C. M. Stutzman, M.D., school physician, Muncy High School; Richard B. Tobias, team physician and school medical examiner, South Williamsport Area School District and Edward G. Werhun, team physician, Wilkes-Barre City Schools.

The entire program was planned by Drs. Buskirk, Grasley and Fleagle and Mr. Sam C. Price of the Pennsylvania Medical Society.

Muscle elicits *electrical activity as it performs work. By recording from the surface of the involved muscles one can secure information about the electrical characteristics of the muscular contraction. By loading the muscle in different ways, various electrical contraction patterns are obtained.*

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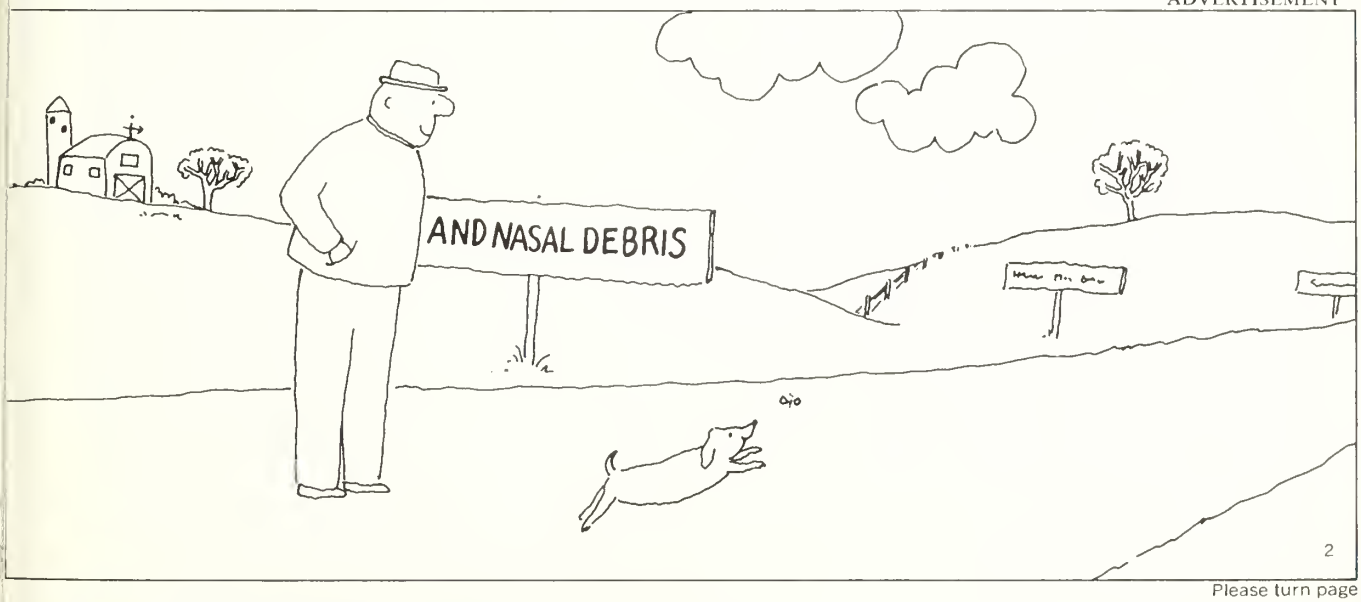

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newsfronts

State Endorses Anti-smoking Book

A newly published book which brings into focus all the mounting evidence of actual crippling effects of the smoking habit on the health of the smoker, has been endorsed by the Pennsylvania Committee on Smoking and the Health of Youth, said Charles L. Leedham, M.D., chairman.

The book, "Tobacco and Your Health: The Tobacco Controversy," was written by Harold S. Diehl, M.D., special consultant for research and medical affairs to the American Cancer Society. It is published by McGraw-Hill, New York.

"There is no longer any doubt that cigarette smoking causes damage to the respiratory system of human beings," said Dr. Leedham. "Smoking is no longer just a menance, but a known cause of disability and breakdown."

Dr. Leedham, a state health department physician, said that Dr. Diehl's new book should be prominently displayed in school, college, and public libraries, and should be read by parents and educators.

"Since the Committee on Smoking and the Health of Youth is dedicated to the prevention of the smoking habit among children," he said, "it is of vital importance that children be educated into knowledge of the hazards of the habit.

"Children must be warned that smoking becomes a burden not easily dismissed later in life; that every cigarette smoked is a potential threat to health, and that a more promising and healthful life is assured by refraining from the temptation to smoke."

Dr. Diehl, who keynoted the inauguration of the statewide observance of "Education Week on Smoking and Health," in Hershey earlier this year, said at that opening meeting that the elimination of cigarette smoking would be a public health measure comparable to the development of a vaccine that could save 300,000 lives each year.

Magee-Women's Becomes Premee Referral Center

Pittsburgh's Magee-Womens Hospital has become the tri-state area referral center for premature infants. Any infant who, because of very low birth weight or severe medical illness, is considered by the referring physician to be at very high risk will be accepted. However, the hospital stresses the fact that they do not provide surgical service for infants. This service will continue to be handled by Children's Hospital of Pittsburgh.

A special infant transport incubator will be used to transfer the newborn from the referring hospital to Magee. The Freedom House Enterprise Mobile Intensive Care Unit ambulance along with a resident pediatrician will go to the referring hospital to pick up the high risk infant. The pediatrician will give necessary emergency treatment to the infant at the referring hospital before leaving for Magee or at any time it is indicated during the trip.

Pa. Drug Firm Distributes New Rubella Vaccine

Nationwide distribution of Merck Sharp & Dohme's newly-licensed live virus German measles (rubella) vaccine has begun with initial shipments of over 650,000 doses, the company has announced.

The company said it will distribute more than 2,000,000 doses of the vaccine by the end of August.

Licensing of the one-shot vaccine for marketing was announced by the federal government, based on the recommendation of the Public Health Service's Division of Biologics Standards and its medical and scientific advisors, following more than two years of laboratory and clinical testing, during which more than 18,000 children and adults received the vaccine.

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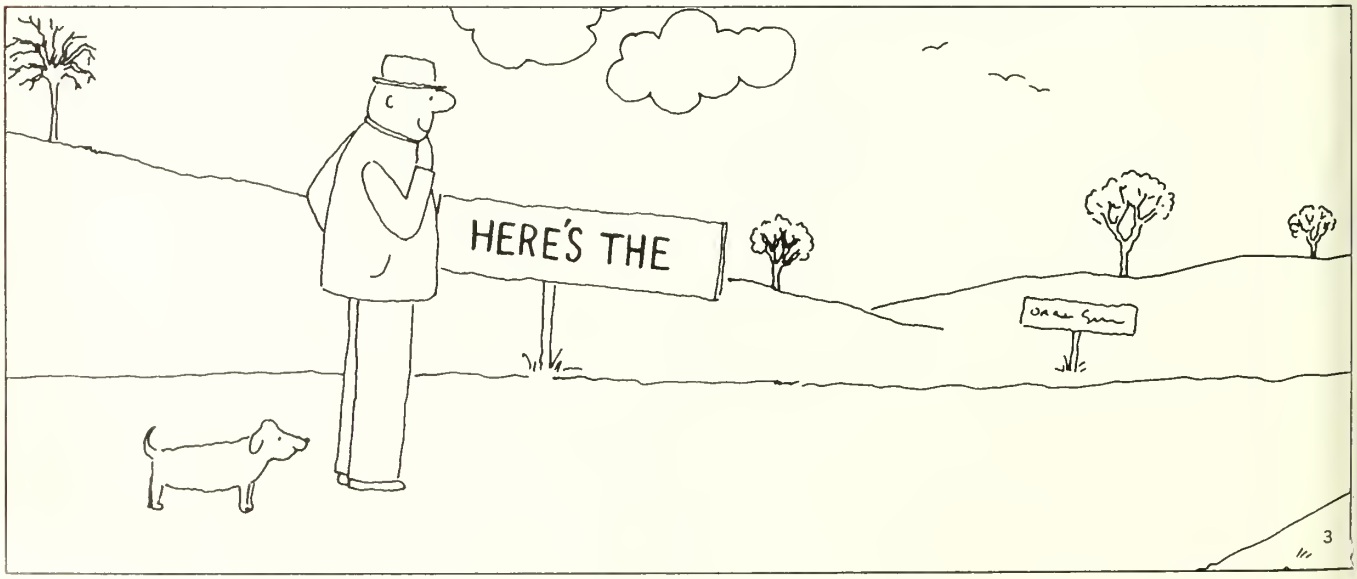

Drug, Government Cooperation Recommended

Without abdicating to federal regulatory agencies, the pharmaceutical industry should join with government in clearing up misunderstandings which impede medical progress, the chief executive officer of a major drug company has declared.

Speaking at the annual meeting of the American College of Legal Medicine, Dr. J. Mark Hiebert, chairman of the board of Sterling Drug, Inc., said:

"I do not ask government to drop its watchdog function nor business to abandon its militant attitude against over-control. Both concepts are necessary parts of the system of checks and balances—but remember, too, that both are essentially negative functions and that health advances are made only through positive effort."

Dr. Hiebert said it is necessary for industry and government to improve communications in order to achieve the common goal of a better national health standard. He urged the joint establishment by government and the drug industry of guidelines for progress, with both parties sensitive to each other's needs, and, above all, to the health needs of the nation.

Three-part committees, composed of representatives of the medical profession, the drug industry and the government, should be set up to work toward health goals, he said. Such cooperative efforts have already proven fruitful in several instances, he stated, such as the current pharmaceutical advertising guidelines which resulted from more than a year of consultation. He also pointed to the working government-industry relationship in the areas of manufacturing and quality control and to the sponsorship by leaders in the drug industry of significant public service projects like The Council on Family Health.

Dr. Hiebert said government is not constituted to develop new health products, although it is making an enormous contribution in basic research. On the other hand, the very profit structure of business allows it to take the risks necessary for the development of new products, he stated.

Since 1940, he said, the United States drug industry has been responsible for the introduction of 525 new ethical drugs—many more than all the rest of the world combined—which have contributed to prolonging life expectancy, reducing infant mortality and overcoming the once tremendous problem of infection. The drug industry has been able to continue to develop such products for the improved health of mankind only by making a profit to stay in business, Dr. Hiebert said.

The time and money factor in developing, producing and distributing a new and beneficial medicine is astronomical, Dr. Hiebert stated. It is profits from the successful existing drugs which make possible the research needed for the new ones. He added, "Like a potential young genius still in the cradle, the product has to be nursed and supported into maturity. No new product survives without the help of the old," he said.

New Health Center For S.E. Philadelphia

"Quality health care with dignity" is the unofficial slogan of the Southeast Philadelphia Neighborhood Health Center, which was dedicated July 19.

Established under a grant from the Office of Economic Opportunity, the center will be operated by Pennsylvania Hospital for the Southeast Philadelphia Community Corporation and the residents of the service area from South St. to Wharton, Broad St. to the Delaware River. The corporation is organized exclusively for charitable, scientific and educational purposes. It is composed of ten residents of the neighborhood, five hospital personnel, five from the Community Action Council, and one each from the city and state government. Donald S. Cook is president of the board. James R. Harris, M.D., is project director.

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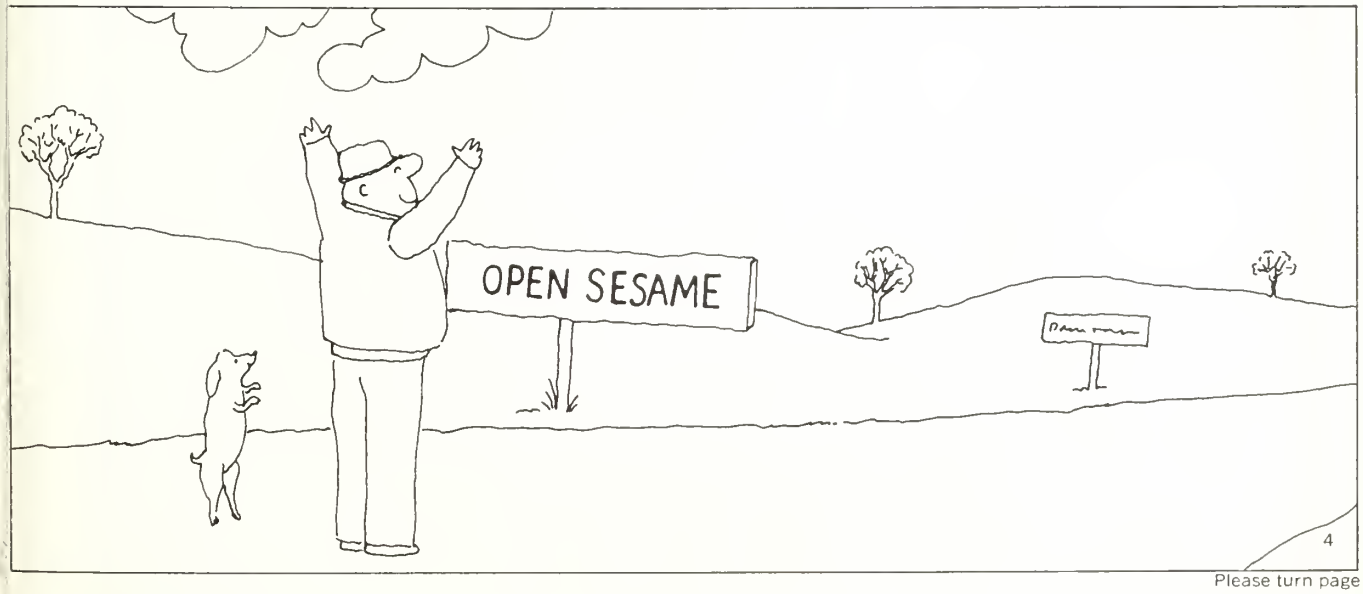

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Working With
Mental Retardates

ART THERAPY

Miss Mary Mahon *(second right), art consultant, demonstrates painting with modeling clay to (from left) Dr. Archibald R. Judd, acting director, Art Workshop at Hamburg State School and Hospital; Lois Colley, director of Nursing at Hamburg; Bernice B. Baumgartner, director of education, Office of Mental Retardation, Pennsylvania DPW and William H. Wolinger, principal of special education at Hamburg.*

Two workshop *assistants complete the final step for transferring Christmas card designs to wooden plaques for permanency.*

Professionals in a wide range of disciplines associated with programming for the mentally retarded are exploring techniques of art at three art workshops introduced this year into the summer in-service programs sponsored by the Office of Mental Retardation, Pennsylvania State Department of Public Welfare.

The purpose of these workshops, according to Miss Bernice Baumgartner, director of education for the Office of Mental Retardation, is to enable varied personnel at state schools and hospitals and in child care centers to learn and experience the kind of art used with mentally retarded children, teenagers and adults. As a result, an increasing number of persons will be capable of reaching the retarded through art media to help them achieve their identities and potentials.

"This is an expansion of the group 'gestalt' approach in our twenty-four-hour plan of structured activities for the development and growth of the retarded," Miss Baumgartner explains. "All involved in working with a retardate begin to understand what to expect of him at the level where he is functioning as they view his art efforts and takes clues for future programming."

More than eighty professional persons—psychologists, teachers, therapists, nurses, child care workers and others involved with the retarded—attended the first three-day Art Workshop held in May at Hamburg State School and Hospital.

Conducted by an art specialist provided by Binny and Smith Art Company as an educational service, the

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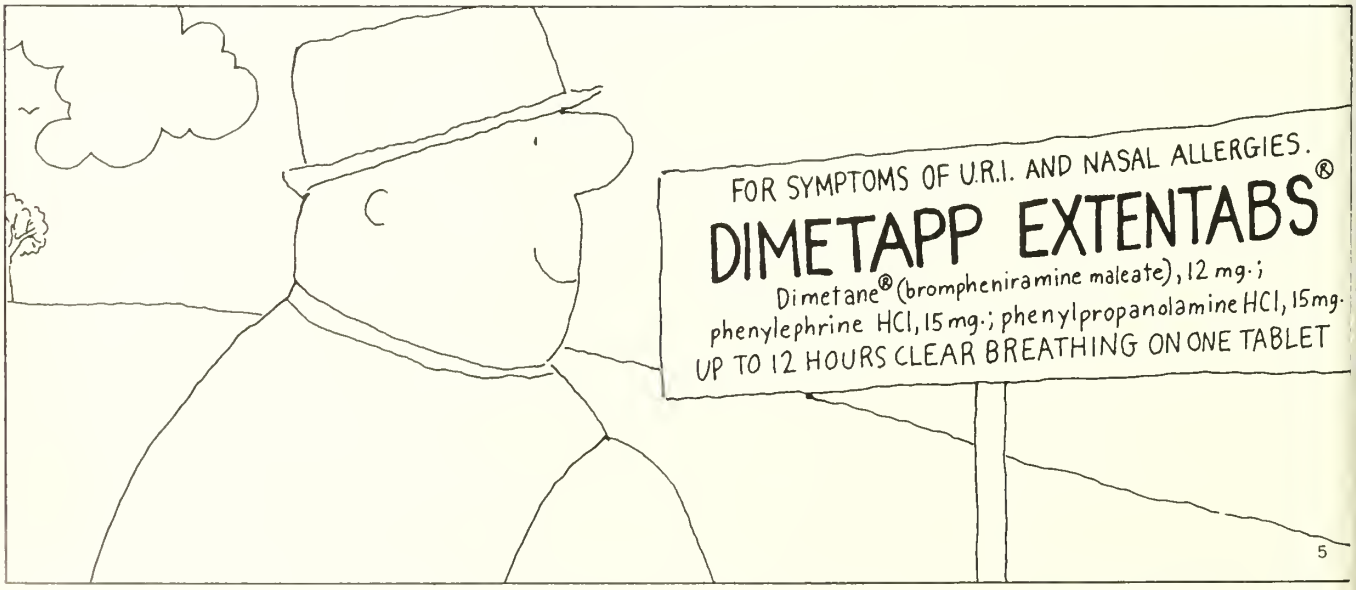

workshop was devoted to familiarizing, or, in some cases, re-familiarizing the participants with art education and some of its materials and tools.

The auditorium on the grounds of the school-hospital became a scene of creative activity as workshop members tried out the techniques presented. Working with poster paints, finger paints, water colors, chalks and crayons, they absorbed the "feel" of these materials.

They noted firsthand the sensory satisfaction and value in terms of manipulation and tension relief afforded by finger painting. For more advanced, three-dimensional effects they applied craft techniques working with paper, paste, papier-mache and modeling clay. From these, miniature figures of animals and people were constructed; flowers were created from egg cartons, designs transferred from Christmas cards.

"It's easy to understand what great therapy this can be, even for us," one of the professionals commented during the workshop sessions as he worked.

In addition to its therapeutic value, authorities on mental retardation agree, expressions through art media help the retarded individual of limited ability communicate ideas and feelings without having to verbalize them. The simple drawing and the crude exploration with different designs and materials, become the patient's means of giving his teacher necessary clues. The teacher on his part responds actively to these messages in order that growth may proceed. One of the major aims of such art work is to establish lines of reciprocal communication.

As a retardate feels increasingly able to express himself through art, he feels a greater degree of mastery over himself and his world. He is able to reproduce the images as he sees them and lives them and tends to be able to verbalize better.

The particular aim of the art workshops for the state schools and hospitals is to coordinate working with art with the institutions' around-the-clock activities. In recognition of the potentials developed through art, the Office of Mental Retardation is advocating teaching through sequencing experiences in art, rather than superimposing learning for which the individual has no readiness and no past experience from which to build. The method is applied "in keeping with each child's ability to succeed, to develop a positive self-image, to become a human being in his own right through the media of art.[1]

The pleasures *of painting with bright, easy-to-use watercolors are experienced.*

Scales have been established to measure growth, to note changes and show total development. When materials are sequenced in terms of the resident's needs and abilities, he may advance from the crudest scribbling stage to learning to write. Some who have been unable to speak, begin to speak. Development is manifested in numerous ways.

At Hamburg State School and Hospital, William H. Wolfinger, principal of special education, currently reports the art program is now being used by many of the personnel with the residents. Even some of the crib cases are learning to express themselves as workers reach them at their levels—such as using a sponge at the end of a clothespin, dipping it in paint and then printing on paper.

"Amazing things can be done for the retarded with planned, concentrated effort," Miss Baumgartner says. "A feeling of progress is emerging from the framework of plans. The results of art work are added proof that much more can be done for the retarded than once was done, and educators, supervisors, parents and staff members in the wards feel the promise of the long-range view of what can be accomplished.

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1 Baumgartner, Bernice B. and Shultz, Joyce B. *Reaching the Retarded Through Art.* Johnstown, Pa.: Mafex Co., 1969.

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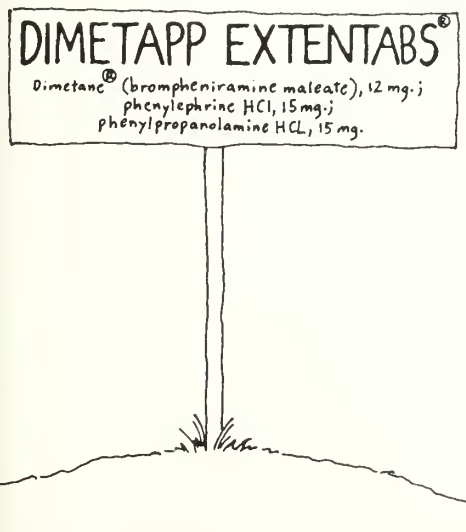

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CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

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6

Recommendations from The State

Tetanus Immunization and Sports

In response to numerous questions raised concerning immunization against tetanus for pupils who are participating in sports, the Pennsylvania Department of Health has made several recommendations regarding immunization.

Because, in some instances, athletic fields are used for horse shows, and in some cases horse manure is used for fertilization, the question of tetanus immunization has been cause for concern.

Although this is visible indication of a probable contamination of the ground with tetanus spores, it should be remembered that 30 to 40 per cent of all soil samples examined are found to contain tetanus spores. In addition, up to 30 per cent of all feces from animals contain tetanus spores. The potential for contamination of wounds with tetanus is evident.

The basic course of tetanus immunization for anyone more than six years of age is as follows:

★ A dose of tetanus-toxoid (alum precipitated or aluminum phosphate absorbed, hereinafter called tetanus-toxoid) or tetanus-toxoid combined with antigens, followed in four to eight weeks by a second dose, and a third dose administered six to twelve months after the second dose.

★ After this initial primary immunization consisting of three scheduled doses, booster doses should be administered at intervals of ten years or at the time of an injury which, in the opinion of the attending physician, merits a booster dose of tetanus-toxoid to ensure the prevention of tetanus.

A schematic diagram of the antibody response to tetanus immunization is presented in the graph. Attention is directed to the minimal or almost undetectable level of antibody response to the first dose of tetanus-toxoid. Within eleven days after the second dose of tetanus-toxoid, an adequate antibody response occurs and persists for several months. The decline in this response during the ensuing six to twelve months is variable.

An amnestic type of response to the third dose raises the antibody concentration to a protective level, which is sustained for many years.

Booster doses are recommended at ten-year intervals, and an emergency dose of tetanus-toxoid is indicated after any injury which occurs more than a year after the last dose of tetanus-toxoid.

Determining the immunization history of each individual is important in the management of members of a team squad.

In any instance where a record of previous immunization compatible with the recommended primary basic immunization is not available, the person in question should be considered not immunized and be given a complete course of tetanus immunization (three doses). In those instances where a written history of adequate tetanus immunization is available, a booster dose of tetanus-toxoid is indicated if a dose of tetanus-toxoid has not been administered in the last ten years.

However, not infrequently, a patient will begin tetanus immunization but fail to complete it. Studies by Volk, et al, and Eckmann, referred to by Edsall, demonstrate "that any dose of toxoid that a patient has had, even a decade earlier, counts as one of his immunizing injections."

Therefore, if the immunization is incomplete but there is a history of some tetanus immunization in the past —DPT, DT or TD toxoids—a dose of tetanus-toxoid should be administered and counted as dose number two. There is evidence from the work of Eckmann that within eleven days after the second dose of tetanus-toxoid patients are amply protected against tetanus (see graph).

It is obligatory that those who have been given this designated dose number two of tetanus-toxoid have a dose six to twelve months later designated as dose number three. Persons immunized in this fashion would then need a booster after ten years or at the time of injury occurring more than one year after the dose designated number three.

It should be reemphasized that the third dose of tetanus-toxoid administered six to twelve months after the second dose is an essential and integral part of the basic immunizing series and is not a "booster" dose.

An excellent discussion of "Tetanus-Toxoid Emergency Boosters" may be found in *The New England Journal of Medicine*, Volume 280, Number 11, Pages 575-581, March 13, 1969. The reader is also referred to the paper, "Current Status of Tetanus Immunization," by Geoffrey Edsall, M.D., which was published in the *Archives of Environmental Health*, Volume 8, Pages 731-741, May 1964.

Hershey Library Services Expanded

A grant award from the Susquehanna Valley Regional Medical Program enables the Milton S. Hershey Medical Center Library to expand its services to physicians of Pennsylvania. Literature searches and the supplying of free photocopying is still in effect. The new services include:

1. Physicians may call the library collect to request information. Telephone number: 717-534-8646. When the Reference Librarian is not on duty (after 5:00 p.m. and Sundays), the physicians request will then be filled as soon as a Reference Librarian is on duty.
2. A TWX has been installed to facilitate the borrowing of items from other libraries which the Hershey Library does not own.
3. Two additional staff members have been added to the reference staff to provide faster service.

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Parent Education Program

Mrs. Matilda Donato *leads a group of fifth graders in a discussion about the needs of a teenager and the problems he faces. At her left is her son Joseph. At far right is Gregory Stea, whose mother has also become a Parent Education Program leader after attending sessions at Read School.*

Interested parents in Philadelphia are now learning to cope with their children's problems before the problems occur. They are learning through the Parent Education Program being conducted by the Pennsylvania Hospital Community Mental Health/Mental Retardation Center in conjunction with the Mental Health Association of Southeastern Pennsylvania.

The Parent Education Program, which started in counties surrounding Philadelphia, did not come into the city itself until November 1967. It was at this time that the program began at Pennsylvania Hospital. Since then, program workers have been meeting regularly in area schools and settlement houses, holding small discussion groups with local parents. Their efforts are directed toward helping parents understand their children and better deal with the stresses of the responsibilities of parenthood. Group

"There's a *10-year-old girl next door. When she gets punished she talks to an imaginary friend. We hear her talking through the wall. She tells her that she won't get punished next time . . ."*

"I was always a *'No' mother. When my kids would ask if they could do something, I'd say no. Until this year. Now I say 'do it."*

"Children need *a certain amount of fantasy to indulge in . . . If the child understands reality and is secure about his feelings, we don't have to worry about his fantasies."*

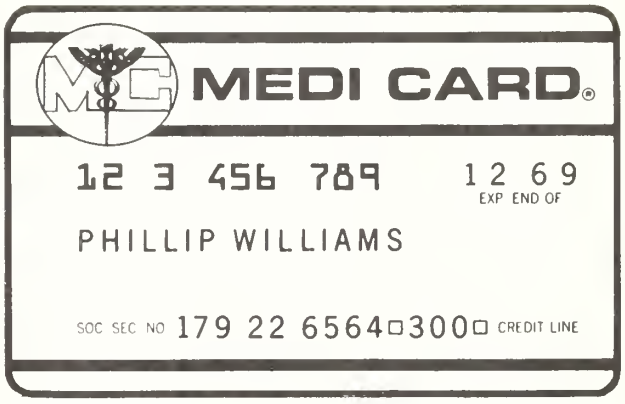
"Parents should *know some psychology . . . to have well-adjusted* children, *the* parents *have to be well-adjusted."*

discussions, which follow such programs as films and play-readings, are led by competent laymen who have completed a formal training program given by the organization.

Mrs. Harriet Prager coordinates and conducts the Parent Education Program at Pennsylvania Hospital. We followed Mrs. Prager during the past year and traced the activities of a small group of women as they progressed through the program to become discussion group leaders and innovators of new parent education projects. These particular ladies are parents of children at Read Elementary School in South Philadelphia. When Mrs. Prager arranged to hold a series of four weekly meetings at the school, they were among the interested parents who attended. At the completion of the sessions, they showed a desire to continue meeting. More sessions were arranged, these conducted on a more intimate level. The study groups gradually led to an eight-week Leadership Training Course for the Read School mothers.

On April 23, 1969, the second annual Parent Education Program Reception was held, honoring new "graduates" of the Leadership Training Course. Among them were the seven mothers from Read School. Guest speaker for the occasion was David Bernhardt, executive director of the Mental Health Association of Southeastern Pennsylvania. He described the program as one which "developed within the community leadership that had a sensitivity to the community and

(Continued Page 38)



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Mr. David Bernhardt, *executive director of the Mental Health Association of Southeast Pennsylvania, addresses the "graduates" of the Leadership Training Course.*

could react to it, and vice versa. Pennsylvania Hospital has pioneered a new extension of the Parent Education Program that started in the Delaware Valley. This hospital has made the *community* an integral part of the program."

A further extension of the program was developed at Read School, primarily by one of the mothers (who is also School Community Coordinator). In May, sessions were held with the fifth and sixth graders, using the same format that was used for the mothers. A film was shown and the children divided into small discussion groups afterwards. Coincidentally, among the pupils were the sons of two of the mothers who are now leaders at Read School.

The Parent Education Program continues at Pennsylvania Hospital, and at the Read School, bringing more interested mothers into its discussions and various projects.

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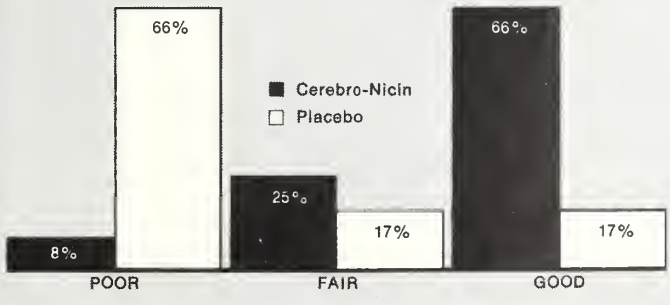

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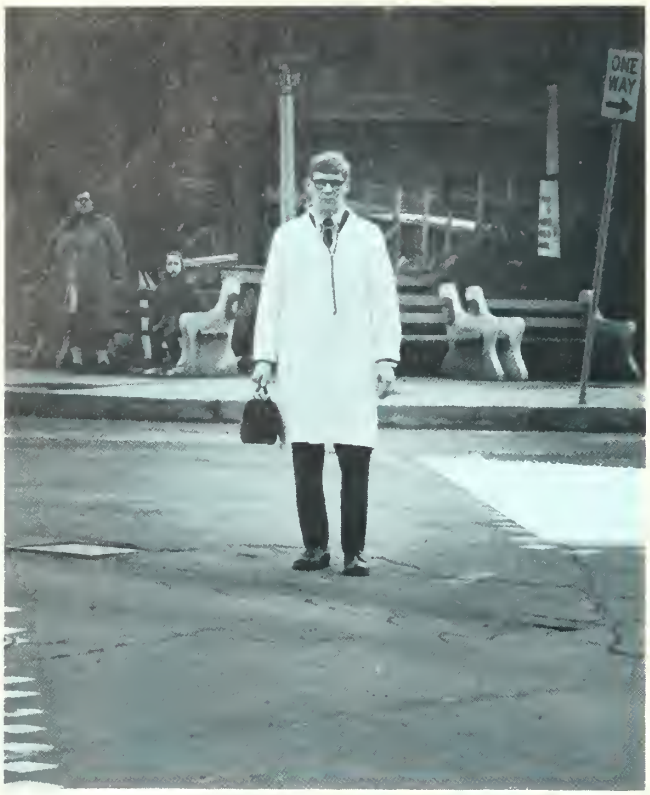

Another Opinion

The Medical Manpower Shortage

STANLEY A. TAUBER, M.D.
Philadelphia

Although I do not agree with Dr. Jacob Gershon-Cohen's solution to the medical manpower shortage presented in the April issue of PENNSYLVANIA MEDICINE, I would congratulate him on introducing a positive note. It is high time for organized medicine in the United States to offer positive suggestions for the solution of our medical needs, rather than simply standing for the status quo or being against proposals set forth to reckon with the problems of the communities' medical needs.

I agree that more and better-trained family practitioners are urgently needed. I also agree that organized medicine must make some changes, and must improve the education of doctors. This improvement, however, must come from educating increased numbers of doctors and from more efficient and intelligent use of specialists in their consultative capacity. This would diminish the needs for specialist training and therefore the time and funds spent on such training could be turned to improving the training of family practitioners.

I cannot agree with Dr. Gershon-Cohen's suggestion to train semi-doctors by so attenuating their education that their privileges and perogatives in the practice of medicine must then also be attenuated and regulated. Nor can I agree with any solution which would fractionate the practice of medicine so that the family physician could not follow his patient into the hospital and supervise and organize the team approach necessary to give the best modern medical care.

If medicine is to retain the holistic approach to the treatment of disease and continue to recognize the multiplicity of the factors which enter into any patient's illness, then the family physician must be the keystone of that patient's treatment and the coordinator of all of the special skills of the consultant physicians which modern medical science is now capable of supplying.

I believe that Dr. Gershon-Cohen's suggestion that modern medical education jades our students and causes them to become dollar-oriented, are easily brushed aside when we examine the ever-increasing numbers of medical students who are involving themselves in community programs in social medicine, public health, mental health, poverty programs, Head Start programs, black student recruitment, in their free time. I also point to the increasing numbers of physicians who are accepting full-time positions at fixed, moderate salaries, rather than compete in private practice where they could make much more money if this were a meaningful, motivating force in their medical attitudes.

I submit that the current extensive education of medical students, if properly oriented would not discourage their wanting to enter into family medicine as a career; but would rather encourage them to enter general medicine and accept as challenging and gratifying the problems found in an active family practice.

It is not necessary to shorten medical education to turn out, with our current educational program, far greater numbers of doctors than we are now producing. With proper reorganization of academic medicine, the majority of the physicians trained will accept family practice as a rewarding career. Retaining the current curriculum will produce a more mature physician with a broader humanistic education who will maintain attitudes which are vital to successful practice and much needed in the world today.

To accomplish these ends, the family practitioner must be reinstated to his position of dignity in the professional, as well as the lay, community. This can be accomplished by readmitting the family practitioner to the staffs of the general hospitals, as well as the teaching hospitals. Perhaps formalizing the requirements for continued post-graduate education for all physicians, either family practitioner or

(Continued on page 42)

is medicine in his future?

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specialist so that they will maintain their continued level of excellence would help greatly in solving the communities' need for good medicine.

All medical schools should produce doctors who are trained for family practice. Students should be taught to recognize the necessity of a well-trained, intelligent and concerned family physician.

All internships should be general practice oriented. The emphasis should be on the holistic approach to patient treatment with more exposure to the socio-economic, psychiatric, and inter-personal family aspects of disease, as well as an acquaintance with public health facilities and training in integrating these into family practice.

With such exposure and training through four years of medical school and a year of internship, young men might find the challenges and rewards of family practice more inviting. Such practice could be professionally rewarding if it allowed him to continue to enjoy the respect not only of the community at large, but also of his colleagues in the specialties; and if he did not have to worry about disenfranchising himself by such practice from his right to practice good medicine in the hospital as well as in his office and in the home.

The present medical schools should re-evaluate their positions; and the filling of their community obligations in terms of creating an atmosphere that would honestly encourage family practice and would raise the number of doctors trained each year. These multi-million dollar plants can train larger classes and thus help overcome the physician shortage. The building of additional first-class medical schools throughout the nation to supply all of the doctors necessary to provide the health care needs of the nation can be done if needed.

If it is imperative to shorten the time consumed in educating physicians then it is possible that the program of medical education could be shortened by revamping the curriculum in a constructive fashion. Deleting unnecessary and repetitive science courses in college could allow the student to get two years of exposure to the humanities and liberal arts, which subjects are important to aid in the broadening and maturing of the young adult personality. The student could go on to medical school where all of his technical and scientific courses could be concentrated in a four or five-year program. This would shorten his training by one or two years and make his services available not only earlier, but at some economic saving to both the individual and the community.

Additional help to the physician shortage could come from a reorientation and re-evaluation of specialist training. By a more efficient and effective use of specialists fewer would be needed. Thus more of the graduating and practicing doctors would be available for family practice.

The specialist should go back to the original intent of such training and become a consultant, rather than a competing practitioner. If he limited his practice to consultation instead of taking over the care of patients, one specialist, with the help of skilled family doctors, could care for many more patients. Specialists should be hospital-based practitioners, rather than office-based. This would insure all hospital patients of the very best type of care while cutting down on the need for specialists by utilizing the skills of each one maximally.

By requiring all specialists to have at least one year of family practice prior to the beginning of specialty training, there would be a greater respect for the problems of both the patient and the family doctor. They would have a greater sensitivity for the patient as a human being in the community setting. At the same time they would have chosen their specialty with more maturity, having truly sampled medicine as a whole.

Finally, to meet the needs of medical care in depressed areas, both city and rural, which now show glaring lack of medical coverage plans are needed to make the practice of medicine in these areas attractive and rewarding to young physicians. Joint local and federal subsidization of the medical education of young doctors would encourage young men to enter this expensive and arduous field of study and make rewarding careers available to qualified but underprivileged students. In return for such free or subsidized education these men would agree to return to these communities to practice for a stipulated number of years.

Furthermore, since among the other problems of practice in such areas is the frequent complaint of being away from the urban areas of on-going medical education, perhaps a system of partially subsidized educational leaves of absence could be worked out whereby a doctor could obtain coverage for his practice while taking post graduate education at stated intervals without undue or unfair economic penalty. Such programs would allow the family doctor to reman part of the medical mainstream and enjoy the rewards of excellent general practice, and the communities involved would get medical coverage to which they are entitled.

I am sure that the foregoing suggestions for subsidized medical school and post-graduate education will evoke cries of socialism and federal manipulations of free practice. However, I think that alarm is unreal and unreasonable. In the first place we are living in a society which is more and more concerned with human welfare. Federal monies now play a major role in medical schools both in research and construction.

Consequently, it would seem much more intelligent and constructive to recognize this trend and help direct it rather than take a traditional negative position. By helping to plan such endeavors we can direct the programs in the most constructive ways and help maintain a maximum of freedom for the individual and local societies as well as local governmental agencies.

We cannot ignore the needs, nor can we pretend that present day society will settle for anything less than a major change in the availability and quality of medical service.

It then behooves organized medicine to take a positive position in helping to find the solution. We must reason together, even when we disagree in our approach, as do Dr. Gershon-Cohen and I. Such dialogue and sharing of ideas and opinions can help the doctors and responsible lay members of the community to meet the challenges before us.

The American Medical Association with representation from state societies and medical schools might consider organizing a study committee for such a purpose. I urge that such a committee invite the Congress of the United States to appoint a task force to work with this professional group, and that a detailed report with positive suggestions for the solution of the medical needs of the United States be prepared by 1971. Then concentrated efforts and programs could be instituted which would guarantee a continuing supply of excellent family physicians in the years to come.

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References: (1) Salerno, L. J.; Ortiz, G., and Turkel, V., Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. (2) Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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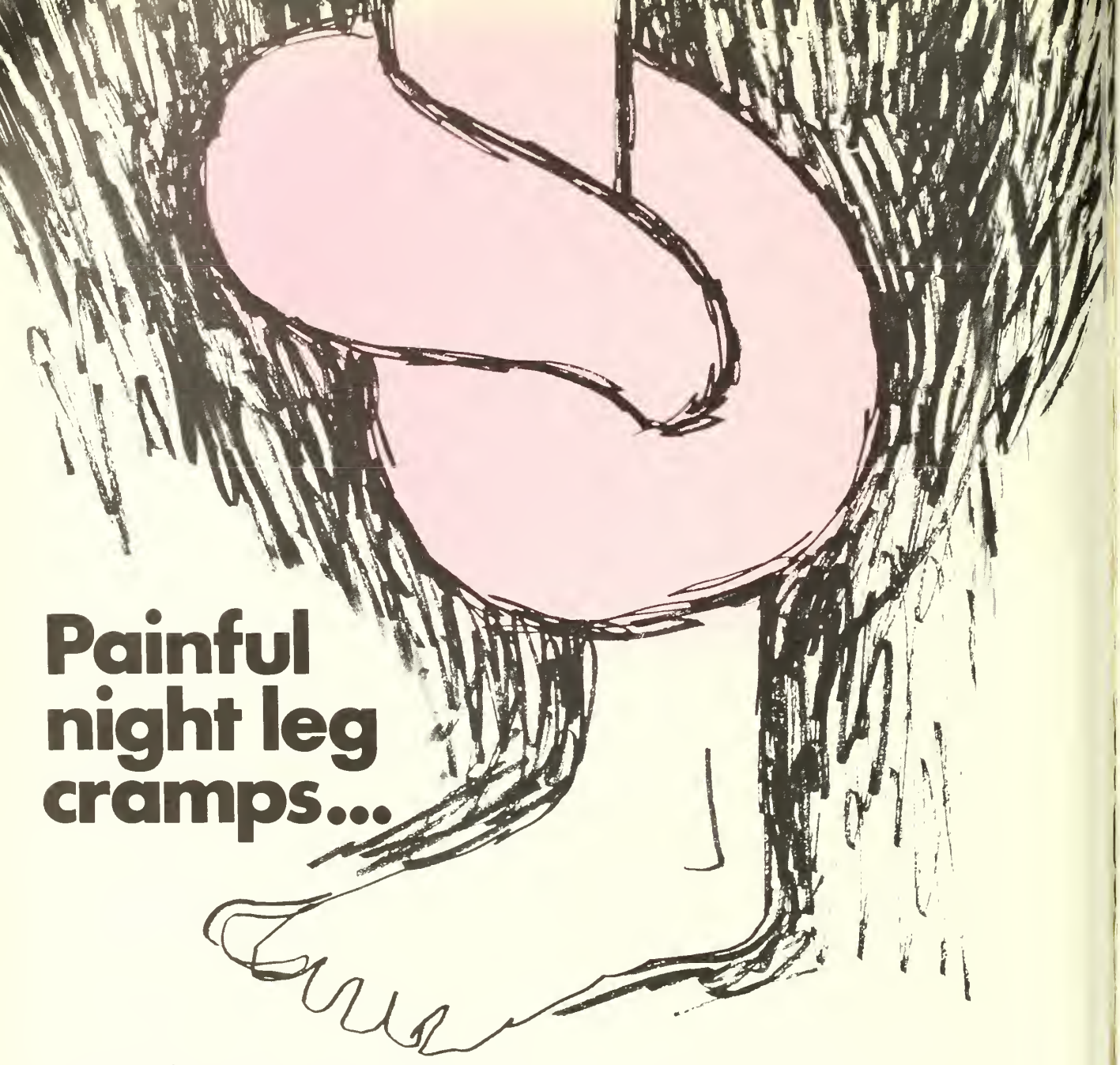

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close-up/MD's

Thaddeus S. Danowski, M.D., has been appointed Chief of Medicine at Magee-Womens Hospital effective July 1, 1969. Dr. Danowski graduated magna cum laude from the Yale University School of Medicine in 1940. He served his internship and residency at New Haven Hospital in Connecticut and then returned to Yale as assistant professor of medicine. He came to the University of Pittsburgh in 1947 as a Renziehausen professor of research medicine in which capacity he served until 1956. Since that time he has been professor of medicine and chief, section of endocrinology and metabolism. He has been on Magee-Womens staff since 1949.

DR. DANOWSKI

Robert H. Kough, M.D., Danville, of the department of internal medicine, Geisinger Medical Center, has been elected to the board of directors of Capital Blue Cross. He will serve a three-year term as a representative of the medical profession.

New officers of the Pennsylvania Radiological Society, elected at the annual meeting in Hershey, are: **Frank R. Kinsey, M.D.,** president; **Newton Hornick, M.D.,** president-elect; **Herman C. March, M.D.,** vice-president; **Theodore A. Tristan, M.D.,** secretary; **Roy R. Greening, M.D.,** treasurer; **Marlyn W. Miller, M.D.,** editor; and **Roderick R. Tondreau, M.D., William J. Tuddenheim, M.D., Norman B. Tannehill, M.D., Alan W. Shriver, M.D.,** and **John H. Harris, Jr., M.D.,** councilors. Dr. Tondreau, past-president, presided at the meeting.

J. Stauffer Lehman, M.D., professor and chairman, department of radiology, Hahnemann Medical College, received the annual alumni award of the Hahnemann Medical College Alumni Association "in recognition of his loyal devotion to Hahnemann and its student body. . . ."

Antolin Raventos, M.D., Jonothan E. Rhoads, M.D., George P. Rosemund, M.D., Michael B. Shimkin, M.D., and **J. Gershon-Cohen, M.D.,** all of Philadelphia, were among the speakers at a conference on breast cancer held recently in Washington. Drs. Raventos and Rhoads are from the University of Pennsylvania School of Medicine. Dr. Rosemund is past president of the Philadelphia Division of the American Cancer Society and he and Dr. Shimkin are both associated with Temple University Health Sciences Center. Dr. Gershon-Cohen is associated with Albert Einstein Medical Center.

Robert C. Prall, M.D., Philadelphia, has been named director of the child psychiatry residency training program which is a joint project of Woman's Medical College of Pennsylvania and Eastern Pennsylvania Psychiatric Institute. He has been director of the children's unit at EPPI since 1955, and has a private practice in child psychiatry and adult and child analysis.

DR. PRALL

Alma L. Young, M.D., and **Lucienne T. Lanson, M.D.,** Philadelphia, both of the faculty of The Woman's Medical College of Pennsylvania, have left for Ethiopia, where, at Princess Tsahia Hospital in Addis Ababa, they have replaced a husband and wife team of vaginal plastic surgeons, Reginald Hamlin, M.D. and his wife, Catherine Hamlin, M.D., who have come to the United States to lecture and raise funds for their work in Ethiopia.

William A. Sodeman, M.D., Philadelphia, was chosen to serve a three-year term on the American College of Physicians Board of Regents during the college's fiftieth annual session held recently in Chicago.

Russel H. Etter, M.D., York Hospital medical resident, has received a $1,200 grant, as one of twelve recipients the 1969 Mead Johnson Awards, given for graduate training in general practice. Dr. Etter is a native of Campbelltown and received his medical degree at Temple University School of Medicine. He began his residency at the hospital in the Family Practice Program last July.

Ross A. Musgrave, M.D., president of the Pittsburgh Academy of Medicine, and president-elect of the Ohio Valley Plastic Surgeons, recently attended the First International Congress on Cleft Palate, in Houston, Tex.

Guy Lacy Schless, M.D., associate physician to the Pennsylvania Hospital and assistant professor of clinical medicine at the University of Pennsylvania School of Medicine, visited England for the eighth summer in a row as visiting research fellow in medicine at Guy's Hospital Medical School, at the University of London. He did research in diabetes with Professor John Butterfield, as he has in previous years. Dr. Schless was elected a Fellow of the Royal Society of Medicine for his work at Guy's.

Robert L. Evans, M.D., York has been appointed vice-president of medical affairs at York Hospital, President Paul H. Keiser has announced. Dr. Evans will direct medical education programs and represent the hospital in regional and community health planning.

Merle Bundy, M.D., Pittsburgh, has been named president-elect of the Industrial Medical Association, international society of physicians in industry. The announcement was made at the association's fifty-fourth annual meeting held this spring. Dr. Bundy is medical director of the United States Steel Corporation and holds a faculty appointment as clinical assistant professor of occupational medicine at the University of Pittsburgh Graduate School of Public Health.

close-up/MD's

Walter B. Shelly, M.D., Philadelphia, professor of dermatology and chairman of the department of dermatology, University of Pennsylvania School of Medicine, has been elected to the Board of Directors of the American Dermatological Association. Elections were held at the group's annual meeting in Scottsdale, Ariz.

Joseph Hughes, M.D., Philadelphia, was honored recently by the Ex-Residents Association of Pennsylvania Hospital when he was presented with the Jacob Ehrenzeller Award at the group's annual dinner meeting. Dr. Hughes was one of the first physicians in the United States to use electroshock therapy in treating psychoses. The work was conducted at Pennsylvania Hospital, where he is now a consultant to both the department for sick and injured and the institute. He was also cited for his excellence in emergency psychiatric management and for having made some of the earliest known studies of the electroencephalogram.

F. Peter Kohler, M.D., Philadelphia, spent a month recently in Zambia, East Africa, at the invitation of the government there. He lectured and visited hospital facilities in the country. Dr. Kohler is associated with Lankanau Hospital.

Leonard Graziani, M.D., professor of neurology and of pediatrics at Jefferson Medical College of Thomas Jefferson University, has received a National Institutes of Health grant of $71,635 to study the electroencephalographic activity of infants receiving treatment in the intensive care nursery of the university's hospital. Working with him are **Mary Louise Soentgen, M.D., Joan Cracco, M.D., Leonard Katz, M.D., Henry Kane, M.D.** and **H. Mansmann, M.D.**

George T. Wohl, M.D., Philadelphia, has been appointed director of the division of diagnostic radiology at Lankanau Hospital. Lankanau Hospital's radiology department, the oldest in Philadelphia, dating to 1896, the year after Wilhelm Roentgen's discovery of x-rays, is also now among the most modern, following a half-million dollar renovation of the department which has taken almost a year. Dr. Wohl is also professor of clinical radiology at the University of Pennsylvania School of Medicine.

Theodore A. Tristan, M.D., Harrisburg, is editor of a film entitled "Roentgen Anatomy of the Normal Alimentary Canal," which is one of a series produced by the American College of Radiology, for showing to anatomy students, pre-medical students and others in related fields of study.

D. E. Piper, M.D., Dallastown, has been elected president of the York Hospital medical and dental staff to fill a two-year term. He succeeds **John W. Best, M.D. William T. Delp, M.D.,** was elected vice-president, and **Lois Kishner, M.D.,** secretary-treasurer. **Glenn P. Grove, M.D.,** became chairman of the executive committee, replacing **Leo Samelson, M.D. H. Roebling Knoch, M.D.,** was appointed to the executive committee to serve a five-year term.

DR. PIPER

Francis C. Jackson, M.D., chief surgeon at the Pittsburgh Veterans Administration Hospital, was recently elected vice-president and president-elect of the Southwestern Pennsylvania Chapter of American College of Surgeons. Dr. Jackson recently was accepted into membership of the American Surgical Association at its annual meeting.

Bryce Templeton, M.D., formerly assistant professor of psychiatry at the University of Pittsburgh, has been appointed as a full-time medical staff member of the National Board of Medical Examiners, headquartered in Philadelphia.

William A. Barrett, M.D., Pittsburgh, has been elected president-elect of the American Association of Clinical Urologists at the annual meeting in San Francisco. He will be installed next May in Philadelphia. Dr. Barrett served as chairman of the by-laws committee for the 1969 meeting.

Rex Pittenger, M.D., Pittsburgh, was honored recently when he received the coveted Agency Award of the United Mental Health Service of Allegheny County. This is only the fourth time in the past ten years that the award has been made. Dr. Pittenger received the honor for "his outstanding contributions in the development of community services for mentally disabled persons in Allegheny County."

David Cornfield, M.D., director of the outpatient department of Children's Hospital of Philadelphia has been elected president of the hospital's medical staff, succeeding **Alfred M. Bongiovanni, M.D.,** physician-in-chief. Other officers are **John A. Walhausen, M.D.,** vice-president, and **Edward M. Sewell, M.D.,** secretary-treasurer.

Leonard S. Girsh, M.D., past president, Pennsylvania Allergy Association, presided at the annual meeting at which the following officers were installed: **Martin L. Lee, M.D.,** Danville, president, **Macy I. Levine, M.D.,** Pittsburgh, president-elect, and **Gilbert A. Friday, M.D.,** Pittsburgh, secretary-treasurer.

Jacob Schut, M.D., has been named associate in psychiatry at the University of Pennsylvania School of Medicine. He had been instructor in psychiatry. At the same time he was moved up from clinical director to associate director for clinical services at the West Philadelphia Mental Health Consortium, the mental health center serving that area which has as its axis the University of Pennsylvania.

The Pennsylvania Society of Colon and Rectal Surgery elected the following officers for 1969-1970 at its annual meeting: **Joseph B. Sarner, M.D.,** Philadelphia, president; **Robert A. McGregor, M.D.,** Wilmington, Del., president-elect; **Philip J. Ferry, M.D.,** Kingston, vice-president; **Peter V. Martin, M.D.,** Allentown, secretary and **Valentine R. Manning, Jr., M.D.,** Philadelphia, treasurer.

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close-up/MD's

Jesse T. Nicholson, M.D., Philadelphia, has retired from his administrative duties as chairman of orthopedic surgery, division of graduate medicine, University of Pennsylvania School of Medicine, but will continue in his post as professor. He has been a faculty member since 1930, chairman since 1946, and has served as chief of orthopedic surgery at Graduate Hospital, Children's Hospital, Pennsylvania Hospital and Lankanau Hospital. A portrait of Dr. Nicholson was presented to the university by **Robert E. Forster, II, M.D.,** on behalf of Dr. Nicholson's colleagues and students, at a reception given in his honor recently.

Two members of the faculty of the Hahnemann Medical College were honored for their excellence as medical educators at the 122nd commencement exercises. Christian A. and Mary F. Lindback Foundation Awards were presented to **William C. Kashatus, M.D.,** assistant professor of pathology, and head of the section of clinical pathology, and **Elliott L. Mancall, M.D.,** professor of medicine and head of the section of neurology.

A physician who started his medical practice making his rounds in a horse and buggy, and was one of the first physicians to make rounds by automobile in 1903, was honored by the Hahnemann Medical College at the 122nd commencement exercises. Ninety-seven-year-old **William Bentley Griggs, M.D.,** Jenkintown, who is still in the active practice of medicine, was cited on the occasion of his seventy-fifth anniversary of graduation from Hahnemann. Dr. Griggs, emeritus professor of therapeutics, was founder of the well-baby clinic at St. Christopher's Hospital, and has been in past years honored by the Philadelphia County Medical Society, the City of Philadelphia and the Vatican.

Jesse G. Webster, M.D., Wellsboro, has retired after more than fifty years of practicing medicine in and around Wellsboro. A 1914 graduate of Jefferson Medical College, he began his practice after serving his internship at White Haven Tuberculosis Sanatorium and what was at that time Williamsport General Hospital.

Howard Balin, M.D., Philadelphia, recently was awarded support for several interdisciplinary research projects. Working with other doctors from Drexel Institute, he will seek an understanding of the control of progesterone biosynthesis in primates and the development of telemetric devises to monitor muscular contractions of the uterus and fallopian tubes. A grant of $107,213 has been awarded for the first of five projected years of investigation by the National Institute of Child Health and Human Development. Dr. Balin is adjunct professor of biological sciences at Drexel. The Food and Drug Administration recently announced a grant of $94,600 to Dr. Balin and Dr. Aaron Spector, Temple University research director, for the first phase, of eight months, of a five year study of the relationship of oral contraceptives to the development of carcinoma of the cervix. A study of 30,000 patients over a five-year period is involved in the latter project.

Mayer A. Green, M.D., Pittsburgh, was elected delegate of the Allergy Section of the AMA at the recent New York City convention.

Frank A. Oski, M.D., hematologist and senior physician at the Children's Hospital of Philadelphia, has been named director of the hospital's blood bank. Dr. Oski, who is associate professor of pediatrics at the University of Pennsylvania School of Medicine, is the author or co-author of some seventy papers, and is co-author of a book on hemotologic problems of the newborn.

Waldo E. Nelson, M.D., professor of pediatrics at Woman's Medical College, Philadelphia, was named the 1969 recipient of the AMA Abraham Jocobi Award in pediatrics. The award was made during the recent AMA convention in New York, where Dr. Nelson spoke on "Communications, Is This the Art of Medicine?"

Martin Wollman, M.D., Glenside, has been named deputy exccutive director of the Greater Delaware Valley Regional Medical Program, which covers a thirty-two county area containing over eight million residents.

Donald N. Medearis, Jr., M.D., has been named dean of the University of Pittsburgh School of Medicine, it was announced recently by University Chancellor Wesley W. Posvar. He succeeds Francis S. Cheever, M.D., who will devote his full time to his responsibilities as vice chancellor for the health professions. Dr. Medearis has been professor and chairman of the department of pediatrics at the school of medicine and medical director of Children's Hospital since 1965.

Waine C. Johnson, M.D., Philadelphia, associate professor of dermatology and pathology at Temple University School of Medicine, has been named director of the laboratory in the Skin and Cancer Hospital. In his new duties, Dr. Johnson will be responsible for administration of the section, diagnosis, and training of personnel, as well as research.

Bradford Green, M.D., Buckingham, has retired after forty years and 9,000 deliveries. A 1929 Graduate of the University of Pennsylvania School of Medicine, he went to Doylestown Hospital when it was essentially an emergency and maternity hospital. A member of the American Obstetrical Society and the American College of Surgeons, Dr. Green was honored by Doylestown Hospital recently for his years of service to that institution.

Joseph A. Hesch, M.D., Philadelphia, has been appointed to the newly-created post of medical director of the Mercy Catholic Medical Center of Southeastern Pennsylvania. Dr. Hesch has been associated with the Misericordia Division of the center since 1953. A native Philadelphian, he is a graduate of Jefferson Medical College.

Donald Kaye, M.D., has been appointed professor and chairman of the department of medicine, Woman's Medical College, Philadelphia. Prior to coming to Woman's, Dr. Kaye was associate professor of medicine of Cornell University Medical College in New York City.

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close-up/MD's

"People have to find themselves as the unique, separate, individual human beings which they can become. In putting their perceptions in physical form," says Kenneth H. Gordon, Jr., M.D., Temple University associate professor of psychiatry, "they can, in part, do this."

Through their creations, they also can communicate with other people, according to Dr. Gordon, and further know themselves as unique human beings.

In his own right, the noted child psychiatrist is a unique human being who employs the art of sculpture in his practice. He has found it affords him a deeper and more meaningful communication and a fuller participation in the human condition.

As a teenager studying anatomy in medical school, Dr. Gordon was fascinated with the structure of the human body.

"Through examining that inert flesh and bone framework in and with which people operate, I became ever more interested in what people are. This led to the study of psychoanalysis."

As a psychoanalyst of children, and as a father, the doctor is surrounded by children and their bounce, their verve, their eagerness for life.

"As I am with them," says Dr. Gordon, "I am privileged to share part of their lives with them. If I take this cup, I then share their perceptions, their thoughts and their feelings."

When Dr. Gordon says "feelings" he means "affects," but he also means the children's physical sensations.

In watching a small child climb on a bench, for example, we see the back bend sideways and the thigh come up, the shoulder rise with its blade, and suddenly we realize that we feel these things ourselves.

These are the children of Dr. Gordon that he has so deftly created in wax.

"To see a child swinging is to re-experience the proprioceptive and kinesthetic sensations you yourself had as a child swinging," claims Dr. Gordon. To see a mother cuddle a baby calls up feelings of cuddling and being cuddled.

In explaining these live and transient movements, tensions and relaxations that make posture and movement possible, make the filling of space by people possible, Dr. Gordon is saying they have so much in them of what living is.

A SWINGING APPROACH

Dr. Ken Gordon's Thoughts on Creativity and Communication

"Certainly in human communication, the amount of movement and expression at a particular time can mean the difference between love and hate, life and death." In the encounters with his young patients, and with his own children, he feels all of this life, this motion inside of him, in his own bones and muscles.

"I find myself longing to express these feelings," says Dr. Gordon, and so he has turned to plastic representation of what he feels—the unique statuary.

Doctor Gordons' medium is a basically hard, petroleum-based wax which he obtains regularly from his Mobil dealer. "It's something you can obtain in abundant quantity," says Dr. Gordon, "and, except for waterproofing cardboard boxes, has little other value, and is very reasonable."

The microcrystalline wax becomes easily workable after soaking in a bucket of hot water for ten to fifteen minutes. Non-sticky, it will remain pliable as long as it is being shaped by the hands.

Most of Dr. Gordon's creations become bronze castings which he has displayed throughout his office-home and which he displays in a Philadelphia gallery.

"Not one of these figures did I set out to do," says Dr. Gordon, "but I just did them."

He explained, for example, that he was with a somersaulting child one weekend and a few days later when he was making a statue, it turned out to be a somersaulting child.

"If it is put aside a few months, then technical flaws can be painstakingly corrected and a few months later, if it looks and feels right, it can go to the foundry."

The initial molding is effortless. When he is lucky, it is that initial effort which contains the essence of what

the Doctor is trying to do—to make a statue that moves even when it stands still; not one that captures motion, but one which has in it some of the same dynamic tension and relaxation which allows a child to swing.

"I also hope that someone who sees it will once again feel in his bones and joints and muscles himself as a swinging child."

Dr. Gordon's wax works are a living reflection of his more profound thoughts on creativity and its influence on people-to-people communication.

"Sometimes talking about creativity reminds me of the man who wanted to find out how the nightingale sang. He cut up a lot of birds and never found one song."

Certain people seem to have a greater need to express their own view of reality than do other people, according to Dr. Gordon. This need appears to be related to the individual's wish to assert the fact that he does perceive things in his own unique way, that he does exist as a separate human ego, a separate entity.

"Now most young children appear to have the wish and need to do this. All of us have been impressed with the verve, the splash, the vitality, of the four to seven year old's productions and we wonder what happens to this splash and vitality.

"Eleven year old girls draw brides and boys draw tanks or airplanes with bullets shooting out of them at other planes. Apparently the older child becomes so interested in developing the actual skills of expression that he subordinates what he is expressing through those skills and thus goes through a period of rather sterile production."

Dr. Gordon points out that some people do appear to have a need to get back to the subject matter of expression in later years. These are the people we call artists or would-be artists.

An individual's need to portray his perception of reality Dr. Gordon believes has something to do with a very early life experience.

During early months of life, the mother and baby function as a symbolic unit. The baby is unable to distinguish himself from his mother and in a sense the mother thinks of the baby as part of herself.

In order for proper development to occur, Dr. Gordon indicates that the baby must separate from the mother and become an individual human be-

(Continued on page 55)

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ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

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Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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ing. One of the most important and basic ego functions, that of perception, can be, and is, utilized by the baby to assert his individuality.

"If the child perceives something by himself, he can begin to develop his own idea of reality and begin to be an individual."

Some children, according to Dr. Gordon, appear to be endowed with an ability to perceive with unusual sensitivity. Other children may receive from their mothers or mother substitutes an exceptional type of benign stimulation which encourages the development of acute and discriminating perceptions and at the same time, protect the babies from overwhelming or noxious stimuli. Some parents for some reason, perhaps by smothering the child with love, may interfere with the separation-individuation stage of development.

"In this situation, the infant may have to make a much greater effort to assert himself as an individual, and may then develop an unusually acute and sensitive type of perception which is keen and unique because he had to fight so hard to get it, keep it, and develop it.

"Following this beginning of individuation, the child can develop his perception to a high degree if he has opportunities for multiple and diverse sensory experiences—exposure to sights (leaves, flowers, oceans, mountains, trees, animals, pictures); exposure to sounds, touches, smells and proprioceptive and kinesthetic experiences (swimming, climbing, swinging, somersaulting)."

Dr. Gordon says that if people with such backgrounds are also endowed with the potential for developing certain skills they might feel driven to put into concrete form their own unique perceptions—a source of satisfaction which would allow the experience of perception in a concrete way and show himself that he really does exist as a separate human being. It would allow him to participate more fully in the human experience.

Creativity, which is a means of expression, is perhaps more importantly a means of communication.

"People are alone on this planet even though they are members of organic social groups," says Dr. Gordon. "People have a great longing to communicate and be intimate with other people, yet this is a difficult thing to do and, as we all know, is a most ephemeral thing."

The artist, for example, does more than assert his individuality. "I believe that he makes an effort to communicate his own unique, peculiar image of reality by putting it into form that other people can experience and

(Continued on page 59)

THE RESPONSE GAP

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All antidepressants take time to work. With Aventyl HCl, patients who will respond often begin to receive symptomatic relief within the first week of therapy. They may report sounder sleep, better appetite, increased interest, or other noticeable improvement in mood or activity.

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*Mendels, J.: Comparative Trial of Nortriptyline and Amitriptyline in 100 Depressed Patients, Amer. J. Psychiat., *124*:59 (Feb. Supp.), 1968.

10 mg.† 25 mg.† 10 mg.† per 5 cc.

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Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two weeks after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl HCl under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Patients receiving a tricyclic antidepressant (e.g., nortriptyline) may respond poorly to hypotensive agents such as guanethidine.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily
10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily
10 mg.—Ages three to six, 1 Pulvule one to three times daily
Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily
Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

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have a chance to understand. His satisfaction then becomes a double one. He not only finds himself but he communicates with other people.

"Why are some people content with art forms that are extremely ephemeral, such as a masterfully baked cake, where others must build a Parthenon?"

Dr. Gordon believes that through communication, people convince themselves of their own unique and separate existence. This is not in any way to denigrate communication or the need that people have to be close to someone. Without human relations, there is not much that is important.

"Communication becomes possible when a person who knows who he is reaches out to communicate with someone.

"It appears to me," says Dr. Gordon, "that the creative process itself has two aspects, one of imagery and inspiration, and the other of technique."

The development of technique appears to be one which requires a certain amount of inborn skill, time and effort, constant observation, self-criticism and life long work.

"The fascinating thing to me is the imagery—where it comes from, why it is effortless, how people 'just go ahead and do it.' It appears to me that the reason it is effortless is that the individual allows his mind to work for him and in this way he has his own unique perception of the way things are. He then feels obliged or compelled to translate this idea into physical form.

"This is effortless because it has nothing to do with the ordinary conscious part of the mind. It strikes me that what psychoanalysts call the preconscious part of the mind is at work in creative efforts. This is the part of the mind that allows us to solve problems in our sleep and contains a vast reservoir of sensory, impressions, memories and integrative capacities"

Certainly, the creative person allows his mind to work for him. If he tries to force himself to create instead of allowing himself to create, the result is usually either a copy of something he did before or an army manual.

"If he allows his mind to work for him," says Dr. Gordon, "he will automatically perceive things in a unique way. His perceptions are unique because people are individual and unique. We have barely scratched the surface of human abilities, perception, and potential."

Photographs provided through the courtesy of CAPSULE, publication of the Temple University Health Science Center, and the Temple University Alumni Bulletin (Philadelphia)

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Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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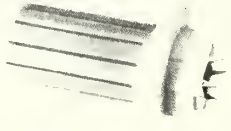

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LEARNING RESOURCE CENTER

THE HOSPITAL LIBRARY

THREE SEMINARS FOR PERSONS RESPONSIBLE FOR HOSPITAL LIBRARY SERVICES

THE HOSPITAL LIBRARY

A one-day conference for hospital administrators, hospital-based medical educators, directors of medical education, in-service medical education directors, and other interested persons, to explain the role of the library in medical and health science education and scientific expansion.

October 23

William Penn Memorial Museum
Harrisburg, Pennsylvania

Presented by: Pennsylvania Medical Society; The Milton S. Hershey Medical Center, The Pennsylvania State University; Hospital Association of Pennsylvania; College of Physicians of Philadelphia; Pennsylvania Department of Health.

Further information may be obtained from: Pennsylvania Medical Society, Council on Education and Science, Taylor Bypass and Erford Road, Lemoyne, Pa. 17043.

HOSPITAL LIBRARY WORKSHOP ON REGIONAL MEDICAL LIBRARY SERVICES

A one-day workshop designed for hospital library personnel without formal training in librarymanship to use regional library services and resources and to expand services in their own institution.

September 24	College of Physicians of Philadelphia
October 1	Woodville State Hospital, near Pittsburgh
October 8	Hollidaysburg State Hospital, near Altoona
October 15	Warren State Hospital, Warren
October 22	Clarks Summit State Hospital, near Scranton
November	Susquehanna Valley Regional Medical Program area, Hershey

Presented by: Mid-Eastern Regional Medical Library Service of the College of Physicians of Philadelphia and the Pennsylvania State Library Division of Institutional Libraries.

Further information may be obtained from: Mrs. Beatrice M. Davis, College of Physicians of Philadelphia, 19 S. 22nd Street, Philadelphia, Pa. 19103.

LIBRARY STAFF TRAINING CONFERENCE

A two-day conference at The Milton S. Hershey Medical Center Library emphasizing training of the hospital library staff. Course in cataloging, classification, reference service and acquisition.

November, 1969

Hershey, Pennsylvania

Expense-paid conference for hospital library personnel in a 27-county area of the Susquehanna Valley Regional Medical Program. Travel expenses, room, and meals will be provided by the Hershey Medical Center under the provisions of the Susquehanna Valley Regional Medical Program grant.

Further information may be obtained from: Mr. Fred D. Bryant, Librarian, The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey, Pa. 17033.

Symbols in a life of psychic tension

M.A.

class of '66

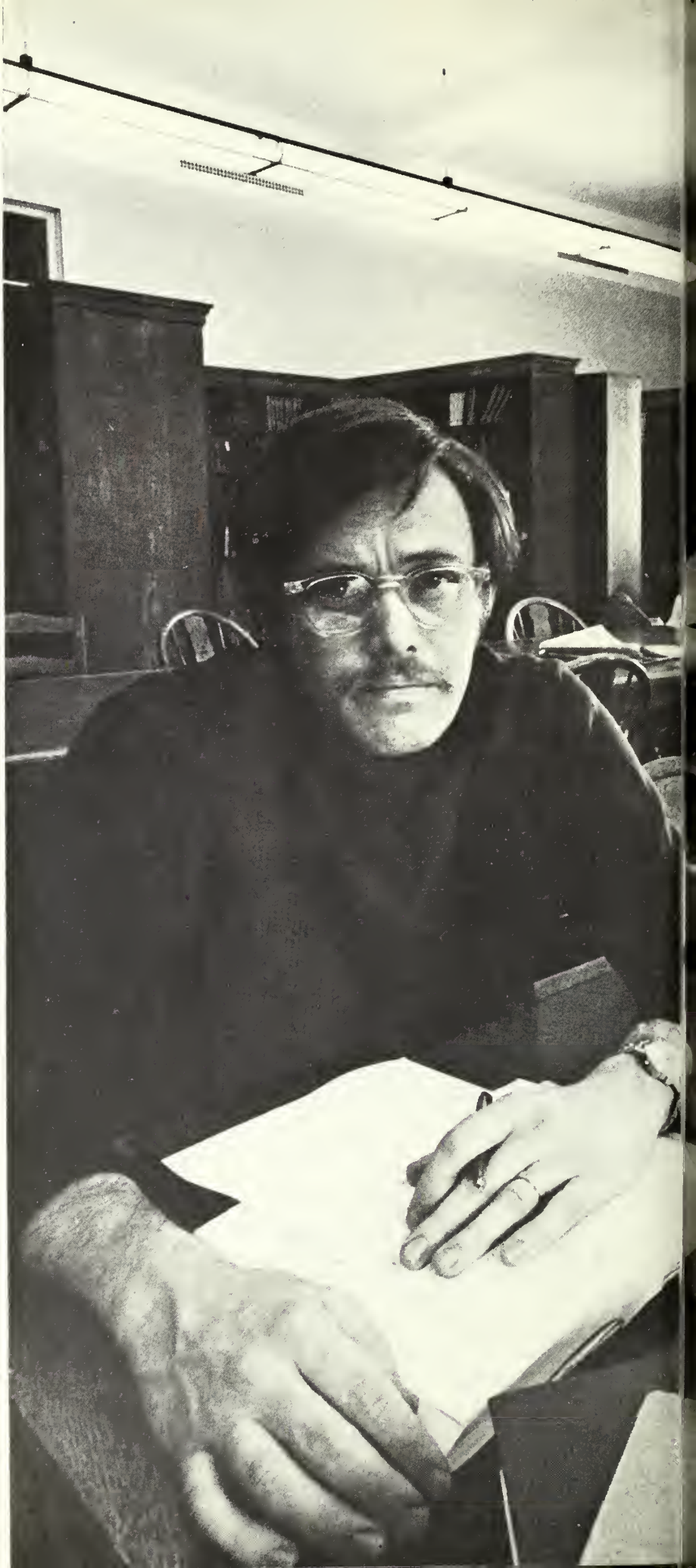
Ph.D.

thesis...in progress

G.I.

series and complete examination normal

(persistent indigestion)



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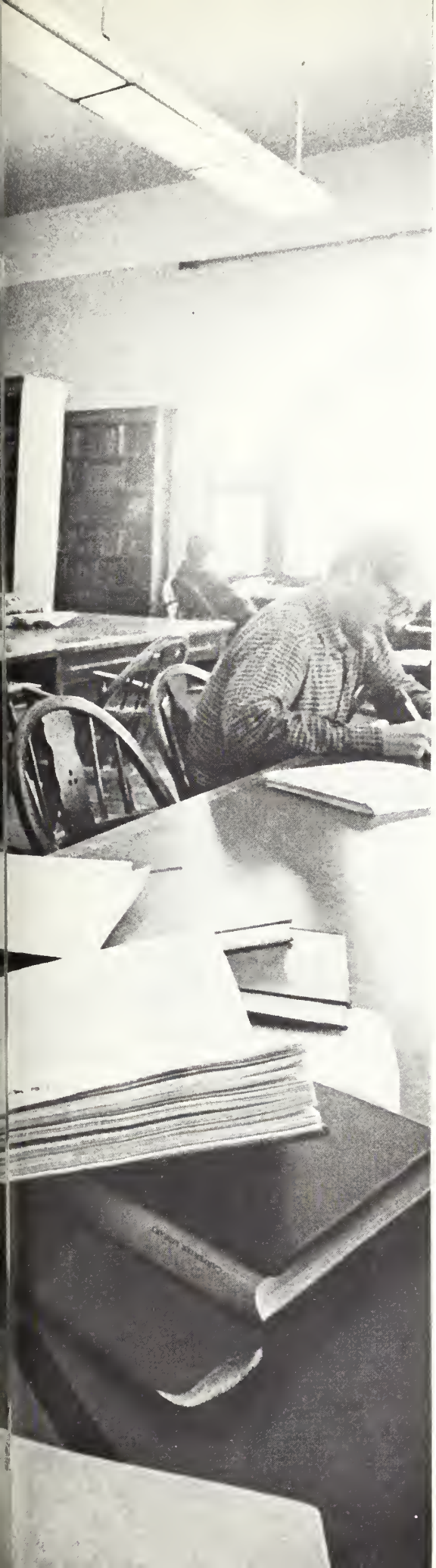

Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

M. A. (class of '66)... Ph.D. (thesis, in progress)... letters that represent a young lifetime of work... a formal education nearing completion. But there are still long, arduous examinations to pass, a doctoral thesis to finish... a period in which stress is often converted into the gastrointestinal symptoms of psychic tension. For this kind of patient—with no demonstrable pathology—consider the usefulness of Valium (diazepam).

Valium can help relieve psychic tension and resultant somatic symptoms, within the first day for some patients. Valium is also useful in psychic tension with associated depressive symptoms. And Valium can help relieve psychic tension-induced insomnia with an *h.s.* dose added to the *t.i.d.* schedule.

Valium is generally well tolerated. In proper maintenance dosage it seldom dulls the senses or interferes with functioning. Side effects most commonly reported have been drowsiness, fatigue and ataxia.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

to help relieve psychic tension
and its somatic symptoms

In the Commonwealth

Eligibility Standards for Aid Restored

Medical assistance eligibility standards that prevailed prior to the cutback on July 1, because of the condition of the Commonwealth's finances, were restored August 1 as a result of enactment of the general fund appropriations for the 1969-70 fiscal year, Secretary of Public Welfare Thomas W. Georges, Jr., M.D., announced.

In signing the general fund appropriations bill, Governor Raymond P. Shafer directed restoration of the medical assistance program to its former level and reinstatement of the former eligibility requirements.

At the same time, druggists and dentists were advised by the Department of Public Welfare that a small group of medically needy persons not on cash assistance who during the month of July were eligible for prescriptions and dental services are no longer eligible for this phase of medical assistance.

Effective August 1 drugs and dental care will not be available to holders of medical assistance cards who are not in receipt of or eligible for cash assistance. For purposes of administrative uniformity the drug-dental services were included in the revised program during July.

Hospital care and physicians' services are being restored under the previous state schedules, with the income ceiling for eligibility for a family of four being returned to $4,000 a year. During July the ceiling was $3,400 and assets were at the cash assistance level. For the same size family the allowable assets were restored to $3,840.

The change restoring the medical assistance program to the pre-July level of benefits will provide medical care cost protection to some 300,000 Pennsylvanians who are not on cash assistance but are unable to meet the expenses of unexpected illness.

Also included in the appropriations bill which was passed by the Legislature just before it recessed for the month of August was $32 million to fund a comprehensive mental health and mental retardation program in Pennsylvania. Federal funds will provide the balance of the $37 million estimated by the Department of Public Welfare as needed for the community mental health, mental retardation budget.

In the Nation

AMA Questions HEW Right to Regulate fees

The American Medical Association has questioned whether the Department of Health, Education, and Welfare has the authority to issue its recent regulation limiting physicians' fees under medicaid.

"We question whether the authority granted by the Congress embraces the promulgation of this regulation," Ernest B. Howard, M.D., executive vice president of the AMA, said in a letter to HEW.

"This regulation appears to reverse the roles of state and federal government established in the law itself."

The regulation limits most physicians' fees to the seventy-fifth percentile of the customary charge—the maximum customary fee of 75 per cent of the physicians in the area.

"Moreover, it has always been recognized that the intent of Title XIX (medicaid), when adopted, was to dissolve any barriers which existed between medical care available to the medically indigent and other citizens," the AMA statement said.

"It also recognized that payment to physicians participating in the government program should be on the basis of reasonable charges, i.e., usual charges of the physician within the customary range of charges for similar services in the community, so as to assure a broad range of participation by physicians in the program and eliminate one of the obstacles to the care of patients on the same level as that provided other persons in the community.

"In departing from its earlier standard, by establishing arbitrary limits on payments to individual practitioners, it should be recognized that the July 1 regulations may again raise a barrier to providing private care to the medically indigent.

"There can be no question that any fee abuses in the program, whether by individual practitioners or other providers, must be ferreted out and eliminated. On the other hand, the true effect of the proposed regulations must be kept in proper perspective, since physicians' fees represent only approximately 11 per cent of the costs of the Medicaid program. Consequently, if the basic concern is with the total costs of the program, the remedy, in our opinion, is not through regulations which restrict physicians' charges."

On the Congressional front, the medicaid law was amended to give the states some relief in fiscal difficulties arising from the program.

States now have until July 1, 1977, to submit comprehensive plans of medical care for all needy persons under medicaid. Under the original medicaid law, participating states had to come up with such a plan by July 1, 1975.

One of the new amendments permits states to reduce their services under medicaid. In the past, they couldn't. But a state still cannot reduce overall medicaid spending.

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Basic Office Treatment of the Alcoholic

Statistics on the incidence of alcoholism may not be accurate, but they leave no doubts about the seriousness of this problem. The cause of alcoholism and the variety of treatment methods indicate that much work needs to be done before we shall have found the answer to this disease which brings so much misery to the lives of so many Americans and their families.

The alcoholic drinks until his health is damaged and his social adjustment is disrupted. Case histories reveal that in the majority of cases the alcoholic has consulted his family doctor for ailments resulting from excessive drinking and that the physician is aware of the harmful addiction. The doctor's frustration at his inability to present an easy cure to his patient falls into the latter's conspiracy and neither dares open up a discussion of the real problem. The patient often interprets this avoidance as lack of interest on the part of the doctor and as his bitterness toward the physician mounts much precious time is lost while his addiction becomes more fixed.

What can the family doctor do for his alcoholic patient? There is much that he can do even though he may not be able to "cure" the patient with a simple drug or a surgical procedure.

The alcoholic patient is often physically sick. As the first step the family doctor must take care of the physical disorders. Regardless of the role which alcoholism played in the development of these disorders, once they develop they are very real and the doctor will be able to practice his profession and gain real satisfaction from the treatment of these ailments. The second step in the office treatment of the alcoholic is the doctor's role in explaining to the patient in a frank and open manner his understanding about the cause of the physical symptoms. In doing so he gives evidence that he considers alcoholism a medical problem which will respond, at least in part, to a medical regime. The doctor can then enlist the aid of other treatment modalities to help his patient avoid drinking. This acceptance of the alcoholic patient increases the latter's trust in the physician and his acceptance of the treatment plan outlined for him. Alcoholics Anonymous, the church, psychiatry, the patient's boss may all be able to play a part.

The treatment and recovery of any addiction is a long and distressful process, but in the practice of medicine the family doctor stands at a strategic position. Often the entire future of the alcoholic may depend on whether this first encounter is felt by both parties as a frustration or as a hopeful challenge.

Carmela F. deRivas, M.D., Member
Commission on Mental Health and
Mental Retardation

Guest Editorial

The Future of General Practice

General Practice has been defined in many ways. There is no agreement. It is this lack of agreement that has led to breakdown in communication, blockade to progress, and, finally, to inability of the medical profession to deliver what it could and should provide for the public. Irrespective of this disagreement, after forty years in the practice of medicine it is perfectly obvious to me that medicine and medical cases, despite their many sophistications, must still rely upon the practitioner who is dedicated to the act as a whole. It makes no difference whether the student ultimately will engage in what is called general practice or whether his field will be more limited. His attitude should be the same.

The general practitioner in many instances is confronted with the problem of centralization. No matter how you centralize there will still be the problem of night calls, the medical care of the young and the old in private offices, the rapport which can exist only between the physician and his patient. No amount of computerizing or paramedical personnel can ever provide for these needs. Patients want the personal care of the general practitioner as well as the special care of the scientific consultant. There are general practitioners who are skillful surgeons, some who are competent obstetricians, some who are excellent pediatricians, and some who are fine cardiologists. It is not likely that one general practitioner is a skillful surgeon, a competent obstetrician, an excellent pediatrician and a fine cardiologist. Frequently the only detectable difference between these high-grade specialists is one of attitude. Undoubtedly many superior specialists do have the attitude and are able to benefit their patients by rendering care beyond the confines of a narrow field. Thus any centralization of our community medical efforts must be endowed with proper by-laws which will assure the general practitioner a place in the overall picture. He must be guaranteed the same quota in administrative and educational goals as the specialists, and he must have

(Continued on page 70)

PENNSYLVANIA MEDICAL SOCIETY

CLINICAL THERAPEUTICS–1969

at the Host Farm Resort Motel, Lancaster, Pennsylvania

SEPTEMBER 15, 16, 17, 18 - 1969

FULL PROGRAM PUBLISHED IN
AUGUST 1969 PENNSYLVANIA MEDICINE

a voice on the centralized board of trustees. Thus, a department of general practice should be developed within the framework of future centralization, the purposes of which will depend primarily on the assumption that the general practitioner or family doctor type practice is desirable and needed.

The need has been recognized by medical educators, leaders in national medical organizations, other medical authorities, economists and those dealing with national problems and needs. Opinion polls and spontaneous responses of the general public to lay articles on medicine indicate strongly that there is a desire, even a demand, by the public for well-trained available family doctors. Availability is most desired by the community at large.

The G. P. must be qualified to serve as health counselor throughout the entire life span of any given individual. He will be dedicated to the philosophy of continuing care. He must be trained to supervise the care of infants, adolescents, mature adults and old people. The management of chronic illness will be his forte; rehabilitation will be his passion. He must be an astute diagnostician, particularly if he is to recognize and intelligently control significant disease in its beginnings. His functions will be to maintain and promote health as well as to prevent or combat disease. He must be well-trained in mental hygiene and clinical psychiatry. Thus the general practitioner of today will know when his patient needs the services of a specialist from a field other than his own—he will follow the patient through the period of care under the specialist so that he can continue when the specialist is no longer needed. A well-established department of general medicine with purposes and functions and educational values as set up by the American Academy of General Practice will aid in providing excellence in health care.

To exemplify the attributes of the ideal physician, permit me to quote from a statement by Milford O. Rouse, M.D., in the *Journal of the American Medical Association* for June 17, 1968:

"I believe sincerely that the attributes of excellence of the typical American physician include the following: Personal integrity, preferably based on religious faith, and a patriotism that impels him to protect and promote the ideals that made our country truly great throughout the decades . . .

"Respect and love for family ties, with time from his busy schedule as a doctor to enjoy and appreciate the privilege of a typical American family . . .

"Participation and responsibility as an average citizen in his church, Chamber of Commerce, service club, voluntary health agencies, other community activities and political involvement as an individual citizen . . .

"A personal program of physical fitness, with systematic recreation, exercise and rest . . .

"A continually expanding acceptance of his three great responsibilities to his patients: (1) scientific or medical excellence, (2) a never-failing "human touch," and (3) consideration of the economic status of his patients to the end that the latter may make the most prudent use of their health-care dollars . . .

"A systematic program of scientific readings and attendance at scientific meetings, with utilization of every available avenue of continuing medical education . . .

"Optimum, responsible, active participation in the work of his county and state medical societies and of the American Medical Association and his regional and specialty organizations, keeping himself informed of the activities of all these groups . . .

"Encouragement of his wife to participate in the work of the Woman's Auxiliary, and of his assistants to be active in the American Association of Medical Assistants . . .

"Friendly, meaningful collaboration with the other members of the health team—medical educators, hospital administrators and other hospital personnel, nurses, dentists, pharmacists, technologists, researchers and other groups . . .

"Active responsibility on the staffs of hospitals where he serves . . .

"Willing participation in studies and analyses of health conditions and health care patterns in his own community, with generous investment of thought and time in improving them . . .

"Support of voluntary community comprehensive health-care planning . . .

"Active participation in regional medical planning activities in his area . . .

"Sincere, friendly interest in medical students, interns and residents . . .

"Willingness to work with government and all other groups, when assured of freedom of judgment and of action . . .

"Daily, enthusiastic promotion of practical lay health education, through pamphlets in his office, *Today's Health,* health talks through communications media and before school or club groups, and participation in annual Community Health Week, health fairs and health and science museums . . .

"Unfailing good humor, tolerance, courage, patience and wisdom."

These attributes I humbly offer every general practitioner with the assurance that he will never fade out of the picture as long as we are available and are willing to give of ourselves, our abilities, and our knowledge.

Charles K. Rose, Jr., M.D.
Reprinted from *DR,* publication of
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PENNSYLVANIA MEDICINE

cancer forum

Safeguard Against Colon & Rectal Cancer

As part of the colon and rectal cancer program, the Pennsylvania and Philadelphia Divisions, American Cancer Society have available proctosigmoidoscopic teaching models for in-service medical training programs. The models have been used in the program for over a year and have been proven to be excellent supplementary aids for teaching purposes with regard to the sigmoidoscopic examination.

The models currently in use are produced by Medical Products Corporation and are significantly improved over earlier teaching mannequins. The models present 25 centimeters of colon, and demonstrate several types of pathology.

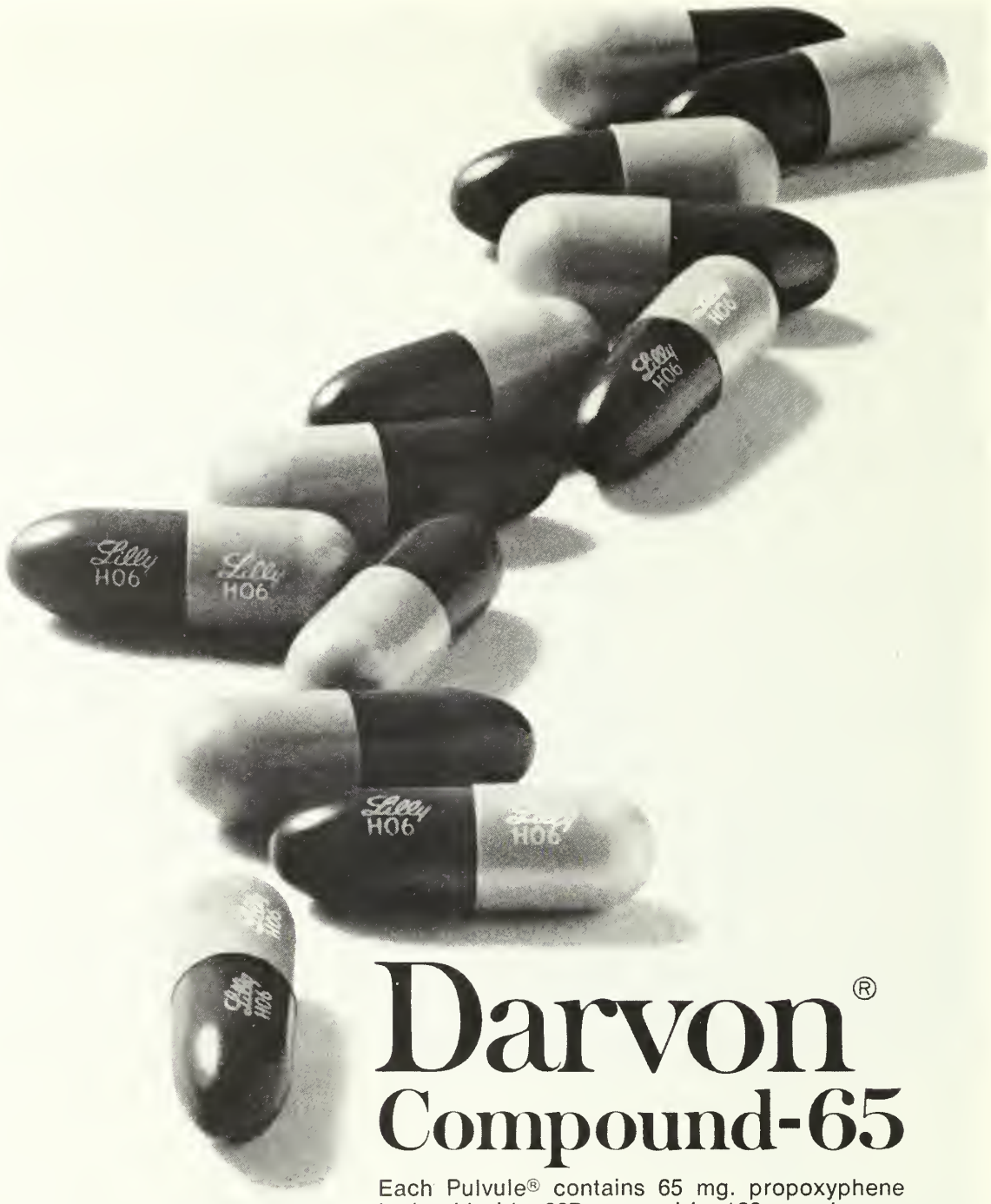
The pathology illustrated includes sessile polyps; pedunculated polyps; ulcerative carcinoma; annular carcinoma; and both idiopathic and amoebic colitis. Because the anatomy and pathology are faithfully reproduced, the mannequins can be used to demonstrate the techniques of proctosigmoidoscopy and to visualize and recognize disease entities. It is interesting to note that the models may be placed in either position for scope passage purposes, i.e., knee-chest, or left lateral recumbant.

The three identical models have been used by both physicians and interns for demonstration purposes prior to actual patient examination. Preliminary instruction regarding the sigmoidoscopic techniques and utilization of American Cancer Society teaching films regarding the technique provide valuable additional help for novices performing the procedure.

On the basis of several initial in-service training programs around the state, the Society's professional education committee recommends the model is a worthwhile additional aid in teaching proctosigmoidoscopic examination techniques and consequently in improving survival rates for a common internal cancer.

The Pennsylvania and Philadelphia Divisions, American Cancer Society, are making the models available on loan for two or three week periods. For further information on the availability of either the models, teaching films, or ancillary teaching aids, write to: Professional Education Director, Pennsylvania Division, American Cancer Society, P.O. Box 4175, Harrisburg, Pennsylvania 17111.

CANCER FORUM – presented cooperatively by the PMS Council on Education and Science, The Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health.



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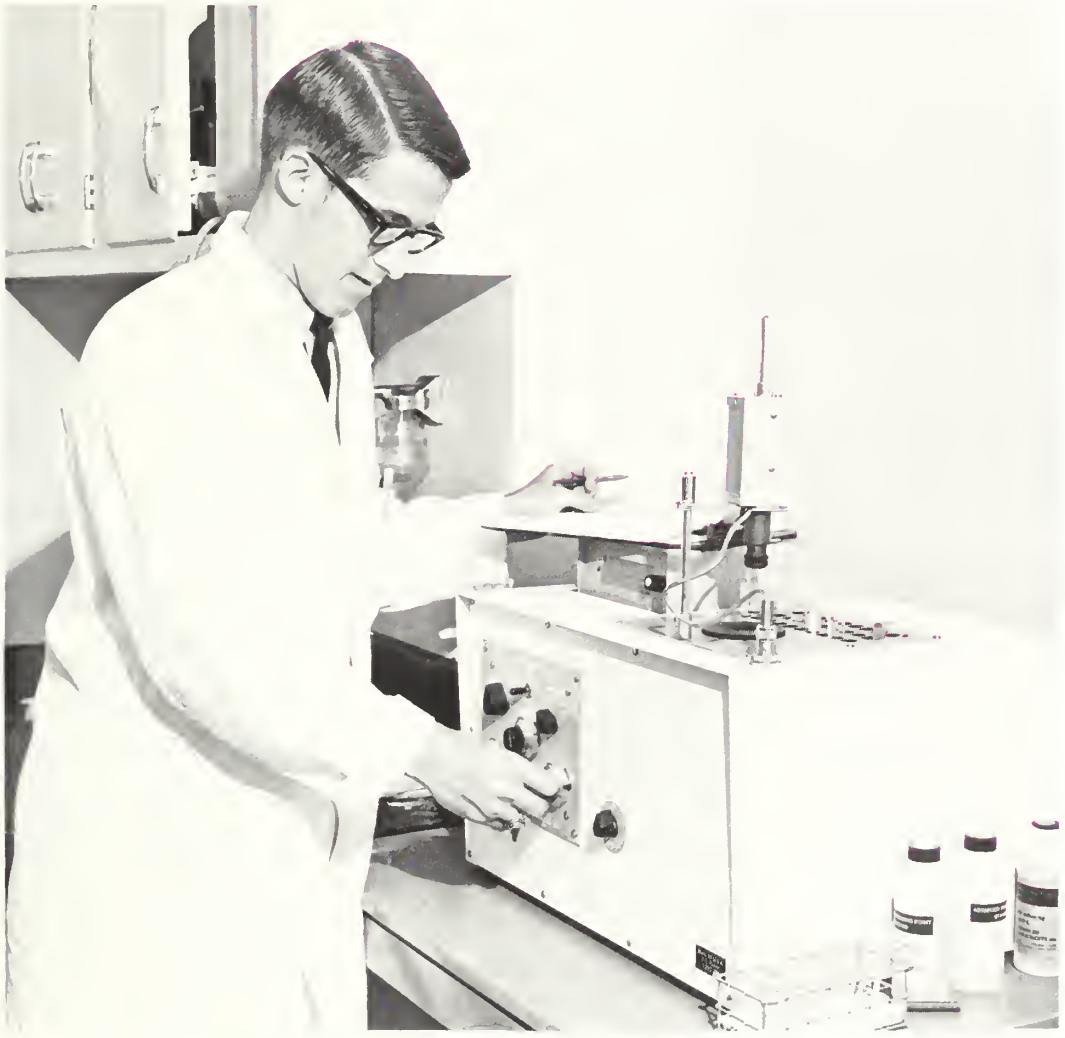

Clinical Osmometry

WALTER W. JETTER, M.D.
Latrobe

The development of instrumentation capable of rapidly determining osmotic concentration has provided a new diagnostic tool in laboratory medicine. Problems in renal, endocrine, and other metabolic diseases are evaluated and therapy managed with the information obtained with this laboratory technique.

Theoretical background: In a container of water there is a random movement of water molecules in all directions. Assume a system in which the solvent water is separated by a selectively permeable membrane from a solution of glucose. The water molecules in the glucose solution compartment are under less compulsion to move than are those in the pure water compartment. In different terms, presence of solute has rendered water less active. As a result there is net redistribution of H_2O and the glucose solution gains volume at the expense of the other. Osmotic pressure of the glucose solution can be measured by determining the hydrostatic force needed to prevent water from entering it.

The osmotic maintenance of normal fluid and solute relationships in the body is a complex matter. Water penetrates most cells readily. Some solute diffuses through cellular membranes and electrolytes pass freely through the capillary membranes separating vascular and extravascular spaces. The net exchange of fluids between extracellular and intracellular

spaces is governed by the osmotic pressures which exist in these compartments. Water movement across the cellular membranes tends to maintain an isosmotic state.

It is customary to speak of the osmotic pressure of a solution but this is hardly if ever measured directly. When a solute is added to a solvent, several characteristics change. Spoken of as colligative properties, they include depression of solvent freezing point, increase of osmotic pressure, increase of solvent boiling point and several others.

A gram molecular weight (Mole) of a nonionizing compound dissolved in 1 kilogram of water exerts an osmotic pressure of 22.4 atmospheres against a semipermeable membrane. It also depresses the freezing point of water solvent 1.86° C. Both colligative properties, osmotic pressure and freezing point depression depend directly upon solute particle concentration and are independent of the chemical nature of the dissolved material. In modern osmometry freezing point measure serves as an index of osmotic pressure, or osmotic concentration (a better descriptive term to use). Solutions of ionic compound exert greater colligative effects than do those of nonionic compounds by the extent to which dissociation occurs. A small ion is a solute particle, its colligative effect is just as great as is a large glucose molecule.

"We have found osmolality measure of urine helpful in many clinical situations, especially in urine concentration and renal function studies."

The unit of osmotic measure is the Osmole, employed [as milliosmoles (mOsm)] for biological fluids. One Mole of a nonionic compound dissolved in 1 Kg of water has an osmotic concentration of 1,000 mOsm/Kg H_2O. The term osmolality has been coined to define this osmotic pressure effect of a solution.

The average freezing point of normal serum is −0.53° C. Since a 1,000 mOsm/Kg H_2O solution depresses the freezing point of water 1.86° C, the determined osmolality of serum is 285 mOsm/Kg serum H_2O ($1{,}000 \times \frac{.53}{1.86}$ = 285 mOsm). Conversion of all osmolality values to a per kilogram solvent water basis has the advantage of permitting direct comparison of such divergent body fluids as serum and water. Serum, for example, has only a 90-93 per cent water content.

Measured serum osmolality is considerably less than the theoretical calculated value; for example, a 140 mEq/L serum Na might be expected to produce 140 mOsm/L serum H_2O effect or about 152 mOsm/Kg serum H_2O. The explanation is complex. Many ionic compounds in serum dissociate less than 100 per cent. Also some ions are bi- or trivalent. Then there are negating influences of proteins on colligative properties of ions in solution to consider as well as numerous complex interionic depressing effects. Sodium and its salts with other electrolytes actually account for about 275 mOsm/Kg serum H_2O. Nonionized organic compounds, principally glucose and urea, add an additional 10 mOsm/Kg serum H_2O. Protein is polyvalent and contributes little. This explains the seeming paradox of cations being responsible for a greater osmotic pressure effect than does the anionic content of blood serum. Table I shows the contribution of the various constituents of normal human serum to osmotic concentration.[1]

Normal Values: Development of the freezing point osmometer has made osmotic concentration measure feasible for routine work. We now include osmometric analysis routinely in all serum electrolyte determinations. Our average value for serum is 285 mOsm/Kg serum H_2O with a range of ± 10. There is no appreciable difference between serum and plasma when heparinized vacutainers are used.

We have found osmolality measure of urine helpful in many clinical situations especially in urine concentration and renal function studies.[2, 3] Normal values in urine are given in the section on urine to follow.

Serum osmolality above 300 mOsm/Kg serum H_2O and below 270 mOsm/Kg serum H_2O are considered definitely abnormal from the standpoint of clinical interpretation. Most values on the hyperosmolal range fall between 300-350 mOsm/Kg serum H_2O. Our highest value was 405 mOsm/Kg serum H_2O. Hypo-osmolality occurs less frequenty. Our lowest value was 235 mOsm/Kg serum H_2O in a person with salt depletion and excessive water intake.

Correlation of serum osmolality with electrolyte and non-electrolyte solute

Serum sodium concentration shows a close linear relationship to serum osmolality. In the absence of hyperglycemia or azotemia the $\frac{\text{serum mEq/L Na}}{\text{serum osmolality}}$ ratio = 0.47 to 0.48. A rule of thumb equation is to double serum sodium concentration and add 7 to approximate serum osmolality. Glucose and urea are non-ionic and account for

relatively small osmotic pressure effects: a 1 mOsm/Kg serum H_2O effect is exerted by 18 mg% blood glucose or 2.8 mg% BUN. Knowing serum sodium, glucose and urea N concentration the serum osmolality may be approximated as follows.[3]

$$\text{Serum osmolality} = \text{Na (mEq/L)} \times 1.86 + \frac{\text{BUN mg\%}}{2.8} + \frac{\text{blood glucose mg\%}}{18}$$

Clinical Application of Osmetric Results

I. SERUM

A. Hyperosmolality (values above 300 mOsm/Kg serum H_2O)

1. Hyperosmolality with decreased $\frac{\text{serum Na}}{\text{serum osmolality}}$ ratio.

Hyperosmolality not due to hypernatremia indicates excess of another solute. Increases in glucose and urea account for most cases of hyperosmolality not due to sodium concentration increase. The accumulation of acid bodies in diabetic and starvation acidosis can increase osmotic concentration by 5-10 mOsm/Kg serum H_2O and even more. Changes in calcium, magnesium and potassium occur in too small concentration to affect serum osmolality materially. The increase in any solute must be a real one to have any effect on serum osmolality, especially if an unionic compound.

When measured osmolality substantially exceeds calculated values (and assuming no basic error in sodium determination) the prognosis is poor. Substances difficult to identify may occur in diverse situations, terminal liver failure, shock, severe infections, toxemia and carcinomatosis. On occasion a disproportionately high serum osmolality may betray the presence of exogenous toxic solute.

TABLE I.

Contribution of Various Constituents of Normal Human Serum to Total Osmotic Concentration [1]

Constituent	Mean Concentration mEq/L		Osmotic Concentration mOsm/Kg serum H_2O Totol—288.9 mOsm		
Na^+	142		139.0		
K^+	5		4.9		
Ca^{++}	5		2.4		
Mg^{++}	2	Total cation effect	1.0		
			147.3		
Cl^-	102				99.8
$[HCO_3]^-$	27				26.4
Proteinate	16				1.0
$[HPO_4]^-$	2				1.1
$[SO_4]$	1				0.5
Organic ions	3.5			Total anion effect	3.4
					132.2
Urea (N)	15mg%		5.3		
Glucose	70mg%		4.1		
		Non-ion effect	9.4		

Case Report One—Diabetic Acidosis. The comatose patient has blood glucose—264 mg%, BUN—30 mg%, Na—141 mEq/L, K—3.4 mEq/L, Cl—114 mEq/L, serum osmolality = 327 mOsm/Kg serum H_2O, serum Na/serum osmolality ratio = 0.43. The next day, after treatment, values were as follows: serum osmolality—286 mOsm/Kg serum H_2O, Na—137 mEq/L, serum Na/serum osmolality ratio = 0.47, Cl—109 mEq/L, pH—7.36, glucose—94 mg%, ketone acids—5 mg%.

In this case serum Na/serum osmolality ratio was below the normal range of 0.47-0.48. The difference between calculated osmolality from sodium level (2 × 141 mEq/L Na = 282 + 7 + 289 mOsm/Kg serum H_2O) and measured osmolality was 35-40 mOsm/Kg serum H_2O. The excess osmotic concentration clearly was due to hyperglycemia and ketone acid solute.

Case Report Two—Uremia. A patient with severe uremia showed serum osmolality—388 mOsm/Kg serum H_2O, BUN—175 mg%, glucose—145 mg%, Na—145 mEq/L, K—5.9 mEq/L, Cl—100 mEq/L, CO_2—10 mM/L, pH—7.25.

Calculated serum osmolality from serum sodium = 297 mOsm/Kg serum H_2O.

Calculated serum osmolality from serum sodium, glucose and urea = 330 mOsm/Kg H_2O.

Serum sodium/serum osmolality ratio = 0.38.

The discrepancy between measured sodium, glucose and urea calculated serum osmolality was more than 50 mOsm/Kg serum H_2O.

Case Report Three—Non-ketotic Hyperglycemia. A patient was admitted with 950 mg% blood glucose, negative serum acetone and serum osmolality of 405 mOsm/Kg serum H_2O. The serum electrolytes were Na—148 mEq/L, K—4.7 mEq/L, Cl—105 mEq/L, CO_2—20 mM/L and pH—7.32. The diagnosis of diabetic non-ketotic hyperglycemia can readily be established from the data.[4] The toxic manifestations in part are due to hyperosmolality.

Case Report Four—Salicylate Poisoning. A child was admitted with vomiting, fever and coma with convulsive episodes of less than twelve hours duration. The serum osmolality was 315 mOsm/Kg serum H_2O. Blood glucose was 125 mg%, BUN—14 mg%, Na—144 mEq/L, K—3.0 mEq/L, Cl—100 mEq/L, CO_2—28 mM/L, pH—7.40, serum sodium/serum osmolality ratio = 0.43. Blood glucose and BUN levels were approximately normal. The serum sodium concentration of 114 mEq/L would be equivalent to about 295 mOsm/Kg serum H_2O. This leaves about 20 mOsm/Kg serum H_2O unaccounted. The finding of blood salicylate of 150 mg% explains the discrepancy between calculated and measured serum osmolality values. In any case of hyperosmolality not accounted for by comparable elevation in sodium, glucose or urea, the possiblity of exo-

There is good evidence to consider osmometric examination of urine preferable to determination of specific gravity.

genous poisoning should be considered. Other poisonous substances which may produce the picture of unexplained serum hyperosmolality are ethylene glycol and oxalic acid.

2. Hyperosmolality and hypernatremia

A high serum sodium concentration is always associated with hyperosmolality. Whether the serum sodium/serum osmolality ratio is normal or increased depends upon the relative amounts of sodium and water. Usually dehydration is the initiating factor, with loss of water exceeding that of salt often attributable to diarrhea in infants, loss of fluid by sequestration in peritonits, intestinal obstruction, paralytic ileus and similar causes. There is not salt excess per se but relative retention of salt over water.

In another group, exogenous salt in excess is the responsible factor. The syndrome is seen upon occasion in the treatment of diabetic acidosis by large amounts of 0.85% NaCl solution without free H_2O. Our highest value of 167 mEq/L serum Na and 340 mOsm/Kg serum H_2O reversed to normal following hydration. The increased serum sodium/serum osmolality ratio of 0.49 should be noted.

Fatal hypernatremia has been reported from salt water feeding to newborn infants. In one fatal case a serum sodium value of 194 mEq/L was reported.[5] Although no serum osmometric determination was available this high serum sodium could correspond to at least 400 mOsm/Kg serum H_2O. Hypernatremia may occur also in old people and those who neglect their own fluid intake for many reasons. Since obligatory fluid loss exceeds the rate of salt loss, dehydration, mild hypernatremia and serum hyperosmolality may frequently be seen.

B. Hypo-osmolality (values below 270 mOsm/Kg serum H_2O).

Hypo-osmolality is of necessity accompanied by a comparable degree of hyponatremia. It is possible for hyponatremia to exist with normal osmolality, however. For example, a 79 year old patient had serum Na—117 mEq/L and serum osmolality of 279 mOsm/Kg serum H_2O, (other data: K—5.1 mEq/L, Cl—81 mEq/L, CO_2—21mM/L, pH—7.31). The BUN was 105 mg% and blood glucose 124 mg%. The serum sodium/serum osmolality ratio is reduced to 0.42. Using the formula for derivation of serum osmolality from sodium, urea and blood glucose levels the value of 264 mOsm/Kg H_2O suggests the presence of still another undetermined solute, perhaps an acid metabolite and/or other nitrogenous solute.

The dual finding of hyponatremia and hypo-osmolality with a normal serum sodium/serum osmolality ratio means there is more H_2O in relation to sodium than normal. It is not the purpose of this paper to discuss specifically the complicated picture of hyponatremia which may occur on an acute or chronic basis. However, a few typical situations can be discussed.

1. Acute—A rapid decrease in serum osmolality occurs as the result of salt loss and lack of intake or internal sodium shifts, accompanied by excessive H_2O intake. Acute diarrhea or vomiting with rapid H_2O replacement has caused the syndrome. It may also be seen postoperatively and following trauma, anesthesia, etc. ADH release leads to decrease if excretion of free H_2O and the urine volume drops regardless of fluid intake. Then, if more water is administered without equivalent salt, serum is diluted with a resulting drop in serum sodium and osmotic concentration.

The syndrome may occur in acute alcoholic intoxication but on a different basis. Here, alcohol-induced ADH depression produces diuresis and electrolyte excretion. The subsequent, almost inappropriate, rebound thirst leads to overhydration and electrolyte depletion. The end stage of hyponatremia and hypo-osmolality is not different from that in the first two cases although the mechanism is different.

2. Chronic—Chronic dilutional hyponatremia (and serum hypo-osmolality) may occur as the end stage of congestive heart failure.[6] Excessive and persistent ADH secretion called "inappropriate" has been seen in patients with visceral cancer and in the so-called "salt losing nephritis" of head injury, etc.. The picture is a complicated one in which osmometric analysis merely points out the hyponatremia that is present.

II. URINE

An important kidney function is the ability to concentrate or dilute urine depending upon the solute load.[7] The traditional measure has been specific gravity determination. At its best, this is an imprecise procedure by the usual hydrometer technique. Moreover, specific gravity is affected by size as well as by number of particles in solution. Actually specific gravity is an index of total urinary solids. Many observers feel the concentrating process of the kidney is best described in terms of total particles excreted, e.g., osmotic concentration.[8, 9] Any straight line relation between specific gravity and osmolality depends upon constance of a diet and especially upon a constant relationship between NaCl, urea and other unionized solute. Specific gravity determinations are erroneously high in the presence of protein, glucose, and radiopaque substances used in I.V. urography. A urine with 4+ glycosuria may show specific gravity of 1.040 whereas osmolality is minimally affected. If a large number of widely varying urine specimens were to be examined, significant differences in osmolality could be undetected by specific gravity determinations because of variations in the nature of the different solutions. To conclude, there is good evidence to consider osmometric examination of urine preferable to determination of specific gravity. Actually, no one suggests specific gravity examination be dropped; urine osmometry should be added. Following are basic data on normal values.

Normal dehydrated subjects excrete urine varying from 800-1,200 mOsm/Kg urine H_2O. Following an excess water load, urine values should dilute to 40 to 80 mOsm/Kg urine H_2O. For practical purposes, anyone concentrating urine beyond 600-700 mOsm/Kg urine H_2O can be said to possess normal renal function. Total urinary solute excretion is referred to as osmolarity. Urine osmolarity varies with the diet and may reach 1,500 to 2,000 mOsm/ 24 hours.

In the application of urine osmometry to clinical problems the following points have been found to be of importance. The list is not all-inclusive but points out areas in which body fluid osmometry can be done with profit.

1. The serum osmolality/urine os-

molality ratio. Normally, this ratio is below 1 and varies with solute and water intake. In intrinsic renal disease the ratio remains close to 1. During the course of chronic progressive failure a loss of concentrating ability is said to occur early, before significant decrease in glomerular filtration. This is demonstrated readily by urine osmolality and rather poorly by the insensitive measurement of specific gravity. In the diuretic phase of acute tubular necrosis the serum osmolality/urine osmolality ratio does not change even with the large volumes of urine produced. The recovery phase can be detected when the ratio begins to decrease progressively below 1.0.

2. The differentiation between acute renal failure and severe dehydration can be resolved easily by urine osmometry. If osmolality exceeds 500 mOsm/Kg urine H_2O the likelihood of acute renal failure can be discounted. In acute renal failure urine osmolality approaches that of the serum. This is an extremely practical and worthwhile test which is considerably more reliable than the specific gravity determination in similar circumstances. Usually only small volumes of urine are available and contamination by foreign material will affect specific gravity more than osmolality. If the patient has been receiving 50% glucose solution glycosuria may elevate specific gravity to "good concentration levels".

3. Differential diagnosis of Polyuria.[3]

a. In diabetes insipidus the urine osmolality is low and serum osmolality/urine osmolality ratio is high. When deprived of H_2O patients with diabetes insipidus respond only slightly, whereas a patient with psychogenic polydypsia under similar circumstances will concentrate urine to 800-1,000 mOsm/Kg urine water.

b. The differentiation between osmotic and water diuresis is sometimes important in various clinical situations, for example, in diuresis following relief of bladder neck obstruction. Osmotic diuresis is accompanied by urine values of 500 mOsm/Kg urine H_2O or higher whereas in water diuresis osmolality of 100 mOsm/Kg urine is seen.

c. "High solute" syndrome—In postoperative patients the syndrome of hypernatremia and rising BUN despite normal or increased urine output may occur. This so-called "high solute syndrome" may be found to be the result of overenthusiastic high protein tube feeding with inadequate free water intake.[10] * This iatrogenic state is easily identified by high urine osmolality (800-1,200 mOsm/Kg urine H_2O) and osmolarity (up to 1,-500 mOsm/24 hours).

d. Low solute syndrome and chronic edema. Sometimes chronic edema in the presence of congestive heart failure exists because of low solute intake. The syndrome is established by reduced urine osmolarity (200-300 mOsm/24 hours) and increasing it to 500-600 mOsm intake daily.

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Summary

Technical developments in freezing point osmometry has made the routine determination of osmotic concentration in body fluids a practical and reliable method. Specific diagnostic applications include the evaluation of concentration and dilution tests, hypernatremia and hyponatremia, acute and chronic renal failure and different types of polyuria. The addition of serum and urine osmolality determination to clinical laboratory routine is worthwhile.

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* free H_2O the amount of urine H_2O over and above that needed to clear solute, isosmotically.

A Working Classification of the Alcoholic Patient

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The problem of excessive drinking must become one of greater concern to medicine, to educators and national leaders. Modern society, blessed with prosperity, with an increasing amount of leisure and disposable income, is turning more and more to the use of alcohol to seek and intensify pleasure, to combat boredom, and to afford relief from feelings of frustration.

Many who use alcohol are unaware of its innate properties, and do not know the disease of alcoholism is insidiously progressive, leading to a disturbance of the ability to deal effectively with the realities of their lives and advancing to a malignant dependence.

In the Judeo-Christian culture, alcohol has had an established place through the ages. Despite long standing disapproval of its excessive use, alcohol has always enjoyed some degree of social acceptance. But as scientific medicine has progressed, more attention has been focused upon the effects of alcohol upon the organic and psychic systems. In the excessive drinking of alcohol is the mechanism of the development of a dependence upon it.

Organic Systems Disease

Empirical data and scientific studies are gradually pinpointing facts of the untoward direct and indirect action of alcohol on the body. This information is indicative of man's inability to cope with this disease-producing psychotoxic agent. Space in this monograph merely allows a reference to this problem.

In order of acceptance liver dysfunction is a cardinal fact related to the excessive use of alcohol. In treatment total abstinence is the rule. The cardio-vascular system does not escape involvement, indicated by the tachycardia and increased blood pressure related to alcoholic indulgence. It is frequently observed that paroxysms of coughing, especially in the morning, seem to be a regular occurrence in the alcoholic. A commonly reported fact of the alcoholic patient is the marked disturbance of the gastrointestinal system manifested by vomiting, retching, loss of appetite, and the "dry heaves". Finally, the disturbed function of the central nervous system is as old as the recorded written history of man in his awareness of the disease, alcoholism. Incoordination, poly-neuritis, impaired judgment, delirium tremens and alcoholic psychoses are constantly seen and reported by those who administer to the alcoholic patient. Thus it is evident that organic dysfunction is a positive occurrence in the syndrome of alcoholism.

It is most difficult to define alcoholism because, paradoxically, while alcoholism is a real entity, it means different things to different people. In a culture that accepts drinking as a badge of social honor the task of considering it as a disease arouses protest. It is not easy to separate social drinking from alcoholism. There is a wide gray area.

Alcoholism and Drunkenness

Drunk is a good word which has fallen into disuse by the substitution of glamorous words such as gay, high, glow, etc. This substitution inhibits clear thinking of the general problem which confronts us. A statement about drunkenness is in order.

There is much confusion in literature and in the news media in that the terms alcoholism and drunkenness are used synonymously. It is a matter of semantics and a misuse of terminology. Drunkenness does not necessarily mean alcoholism. Anyone who uses alcohol can get drunk. It is merely a matter of consuming enough alcohol. Many social drinkers, on occasion, elect to get drunk, while with the alcoholic it is a matter of compulsion. With the former it is more a matter of the moment, with the latter it is a way of life, yet in either case the result can be equally catastrophic.

Many who are arrested as drunken drivers are designated as alcoholics when they are not alcoholics, but just drunk. While some highway accidents are caused by alcoholics who are drunk, the vast majority of accidents are caused by drunken drivers who are not alcoholic.

The above discussion is self explanatory. The misuse of words compounds the confusion in the area of alcoholic studies.

Pinpointing the turn from social drinking to compulsive drinking becomes a Solomon-like responsibility necessitating the exercise of astute judgment. One must have a clear concept of the difference between social drinking and compulsive drinking, because it is compulsive drinking that is the disease alcoholism.

A fine borderline exists in this large gray area, which is ever-changing and difficult to locate. During active practice in this field over the past thirty years, I have found the following classifications helpful for a more clear-cut picture of the complex entity called alcoholism with its many pathological drinking patterns.

Alcoholic Types

1. Alcoholic, Organic

Alcohol has a direct effect on the organic system—the liver, heart, peripheral nerves, blood and pancreas, as previously mentioned. The organic systems may be involved singly or in multiple fashion. However, there is no real involvement of the mental makeup of this drinker. His business, family and social relationships stay intact. When this type of drinker understands the cause and effect of his consumption of alcohol, he frequently elects to delete it from his habit of living.

2. Alcoholic, Psychic

In the psychic alcoholic, alcohol has a direct effect on the alcoholic's reason and judgment. His behavior pattern is altered, as anti-social characteristics make the problems of daily living uncontrollable. His relationship with people is impaired and treatment is obstructed.

3. Alcoholic, Organic-Psychic

Some alcoholics experience both organic and psychic disturbances. In this type there is a simultaneous attack

on both the organic and psychic systems of the body. The body insult is equalled by the disturbed function of thought processes and the mental confusion becomes an iron curtain against the establishment of a treatment regime.

Alcoholism Etiology

1. Alcoholic, Primary

In the primary alcoholic, the psychotoxic effect of alcohol is the sole cause of his dislocation from the performance of the responsibilities in his daily living. Primary alcoholism is considered by some observers to be a metabolic defect which disturbs the normal biochemical function of the body. In such a case, only if the alcoholic can elect sobriety, which means total abstinence, can his competence in daily living be reestablished; the overt and obvious disturbances abate upon divorce from alcohol.

2. Alcoholic, Secondary

The secondary alcoholic suffers from a basic personality upset which makes it burdensome for him to accept the reality of daily living. Some observers think that his alcoholism, like that of the primary alcoholic, is related to an error in metabolism. If one accepts this thought, then one may understand that many inadequate persons may drink alcoholic beverages in a socially-accepted manner without becoming victims of the disease. But the secondary alcoholic, unlike his primary counterpart, finds little improvement in total abstinence because of the basic inadequacy of his makeup, and the task of establishing sobriety in a person of this type is most challenging. At present, this group, in which alcohol is a secondary invader in addition to basic inadequacy, forms the vast army of alcoholics who are incapable of arresting the disease.

The discussion would be incomplete without an attempt to pinpoint the various types of social drinking, where the grays of diagnosis show up, and confusion is the order of the day.

No one sets out deliberately to become an alcoholic. It is more common for one to begin drinking with friends in a social setting or occasionally because of curiosity. But social drinking often progresses to problem drinking, and it is well to give thought to some of the following types of social drinking and to the fact that they may progress into patterns of drinking which are pathological.

Social Drinkers' Syndrome

1. Social Drinker, Acute Sensitization

The person who becomes sick and uncomfortable on very small amounts of liquor is an acutely sensitized social drinker. This type of person usually elects not to drink because of his specific reaction to alcohol.

2. Social Drinker, Temperate

A person who drinks in the most modest fashion with no disturbance in deportment is a temperate social drinker.

3. Social Drinker, Semi-Temperate

A person who is inclined to get a little drunk in a gay, careless way for pure enjoyment is a semi-temperate social drinker. Although at times a little inebriated, he never allows his indulgence in alcohol to interfere with his responsibilities in daily living, in his business or in his family life.

4. Social Drinker, Spree

A spree is a deliberate election to drink to varying degrees of drunkenness. It is characterized by a lively frolic. It is usually a pleasant indulgence in the escape mechanism of alcohol by election, but it is not without risk of a catastrophe as is possible in all states of drunkenness. However the spree is an end in itself and is not continued in compulsive drinking.

5. Social Drinker, Business Cocktail

Many who like alcohol believe that this type of drinking is essential to the conduct of business. This is a misapprehension and occurs where pure work is mixed up with the social side of life, which is an entirely different thing. Wisdom proverbially decries "mixing business with pleasure", and corporations indicate their displeasure when social drinking is confused with the purpose and work of the business world. Liberal drinking excused under the banner of "business" conscripts for the army of alcoholics many who are unvolunteered.

6. Social Drinker, Hangover

A person who in his drinking habit endures the physical and nervous discomfort of the hangover, but who remains competent in accepting his responsibility in community and personal life is a social drinker, hangover type. No tragedy occurs. His discomfort is physical and there exists the mental acceptance that he is a fool to overindulge.

7. Social Drinker, Heavy

A heavy social drinker is one who considers alcohol the paramount elixir of life and who builds all social function around its pseudo-glamor. This type of dependence often leads to alcoholism and from these ranks come many alcoholics.

8. Social Drinker, Weekend

The habit is established by some social drinkers to indulge copiously over the weekend. His drinking is consistent and dominates the character of activity in which he participates. The drinker, by his marriage to the bottle, is restricted in his socializing in the events of the day. The rest of the family and guests are also restricted in their interests because alcohol is "King" and will tolerate no substitution of many wholesome activities others might well enjoy. Many a shadow is cast by the social weekend drinker as he darkens the potential of a pleasurable get-together. On Monday he or she returns to work with little realization of the gloom and unpleasantness their drinking precipitated for others.

9. Social Drinker, Hideout

The executive or competent individual who elects to get drunk in a planned and prescribed manner is a hideout type social drinker. He visits a strange community and holes up in a hotel. He stays completely inebriated over the weekend. Monday he reports for work on schedule as planned. This binge differs from alcoholism, the disease, because the hideout type has complete control over his dissipation.

10. Social Drinker, Catastrophic

Social drinkers are not immune to tragedy. It is not unusual for friends or family to gather, and, as is the custom, serve alcoholic beverages. At times, these innocent affairs explode in violence. A silly, inconsequential argument erupts; without reason, someone produces a shotgun and several people lie dead. More often, with impaired reason or judgment, a socially drunk celebrant leaves the gathering and drives an automobile. The tragedy of drunken driving needs no illustration. It is constantly reported in the news. Frequently, the story is to be found between the lines of print. But such tragedies will persist until

the public fully appreciates alcohol as a psychotoxic agent capable of disrupting thought processes.

The following categories discuss the grouping of alcoholism, the disease, in a specific manner where the signs and symptoms are sufficiently overt that a diagnosis can be established. The chaos in daily living is adequately determined and the diagnosis is confirmed by family, friends, colleagues and the physician.

Alcoholic Patterns

1. Alcoholic, Periodic

This individual at definite or indefinite periods suddenly starts drinking in copious quantities and precipitates himself into a binge. He is difficult to introduce into a treatment regime because with the termination of the binge he is convinced that he will never drink again. In this thought he is safe for an indefinite period, but the next binge is almost as inevitable as night following day. In therapy, this pattern can be broken, but it presents a very serious problem in the reeducation of the patient.

2. Alcoholic, Chronic

The chronic alcoholic drinks daily and his intake is liberal; there accrues an increasing attrition of his capability to perform the ordinary duties of daily living. In addition to his chronic daily consumption, his drinking pattern is at times punctuated by spree or binge drinking.

3. Alcoholic, Quiet

This person, although his conduct and deportment are quiet and dignified (save for the ataxia of his legs and tongue), silently drinks himself into temporary oblivion. The quiet alcoholic is usually respected, and his friends have no difficulty in accepting him as a sick person. The reason the quiet alcoholic is so readily accepted is that as an individual he does not annoy people, he causes no trouble. He or his family should not allow his total disintegration.

4. Alcoholic, Eight-Hour

This is a vicious type of alcoholism of a limited but profound tragedy. It involves a total social dislocation of the family and creates for them a life of periodic hell. The eight-hour alcoholic's drinking starts before dinner in the evening, and with the first drink his reason and judgment are impaired. His personality progressively disintegrates until the offender goes to bed. He may appear nude, micturate on the floor in front of guests and commit all types of social indecencies. On awakening in the morning he is refreshed, looks as if he has just stepped out of a bandbox, and manages his successful business. His friends and colleagues are totally unaware of his Jekyll-and-Hyde stunting the night before. We cannot estimate how often this script is performed in the American home; but is played out far more frequently than an intelligent society would care to admit.

Because of this peculiar syndrome and the authoritative position of the eight-hour alcoholic, he violently resists introduction to a treatment program. The family feels helpless, and the idiotic way of family life continues without abatement or relief.

5. Alcoholic, Binge Drinker

The binge drinker goes on a drinking bout, probably prolonged, the manner of which is compulsive, with loss of control of deportment.

6. Alcoholic, Usual Regular

The usual alcoholic recognizes that he is sensitive to alcohol but elects to continue his drinking pattern. He usually drinks on a daily basis with control. But, finally, control goes out the window, and he disintegrates. He or his family institutes care under medical supervision; the patient compensates mentally and physically, and in short order, he is ready to resume his daily responsibilities. This alcoholic is a successful and authoritative figure; he is his own boss and in command. In spite of his suffering and inconvenience, he is firm in his decision to drink, and in honesty, makes an open declaration of his intention to continue his drinking. He accepts the fact that hospitalization will inevitably follow. His hospitalization is protective, in that it reestablishes his normal physiology and improves his health, enabling him to drink again.

7. Alcoholic, Station Wagon

The station wagon alcoholic is a peculiar breed fomented in the affluent suburbia of our day, where the dissipation is protected by economic status. Money is the protection that keeps him or her from the Bowery, but the ravages of the disease are just as virulent socially.

8. Drug-Dependent Alcoholic

A considerable number of alcoholics are prone to become drug dependent. They seek to ease the rigors of the hangover by use of medicaments and in time become drug dependent. The combination of the use of drugs and alcohol is more difficult to treat than just the compulsion to use alcohol. It is a fact from this group come many suicides and accidental deaths.

Summary

The many faces of alcoholism have been categorized. Far too frequently, a person's concept of alcoholism is a picture of a skid row bum or is equated with slightly excessive drinking without any thought of the disease, alcoholism. People commonly imagine that the simple solution is for the alcoholic to cut down on the amount of alcohol he consumes. But this common view of alcoholism and its treatment is a formula of disaster; it simply cannot work. The disease is compulsive in character and requires a much more direct and stringent attack than "cutting down" implies. The alcoholic must accept the facts of life, which demand of him a complete divorce from alcohol and the astute practice of total abstinence.

Finally, society must accept the challenge of this serious, social medical malignancy. Prevention should be the cardinal keynote of an alert, intelligent society. In my experience, the greatest number of problem drinkers began, benignly enough, as social drinkers.

The classification of the alcoholic is necessary to free the lines of communication among the many workers in the field and to bring a better understanding of the multiple disciplines applied in the therapy of the alcoholic.

The classification describes the overt signs and behavior of different types in order to give a crystal clear picture for the wide spectrum of alcoholism from the incipient signs to the final picture of total disintegration of the alcoholic when the diagnosis is obvious.

Since alcoholism has as many faces as there are individual alcoholics, the classification can be endless. It is the purpose of this monograph to make identification possible regardless of the specific alcoholic under the canopy of this discussion and classification.

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SOCIO ECONOMIC SEMINAR

2:00 PM

COMPREHENSIVE HEALTH PLANNING

WILLIAM J. PUTNAM, D.D.S., Assistant Surgeon General, Regional Health Director, Department of H.E.W., Region II

THOMAS W. GEORGES, JR., M.D., Secretary of Health, Commonwealth of Pennsylvania

MATTHEW MARSHALL, JR., M.D., Chairman, PMS Council on Medical Service

JOHN L. STEIGERWALT, M.D., Regional Comprehensive Health Planning Agency for S.E. Pennsylvania

3:30 PM

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Reviewing *the state program for comprehensive health planning are left to right, Henry V. Walkowiak, director, Office of Comprehensive Health Planning; Secretary of Health Thomas W. Georges, Jr., M.D., and Advisory Council Chairman Peter W. Duncan, editorial director, WCAU-TV Philadelphia.*

Planning for Better Health

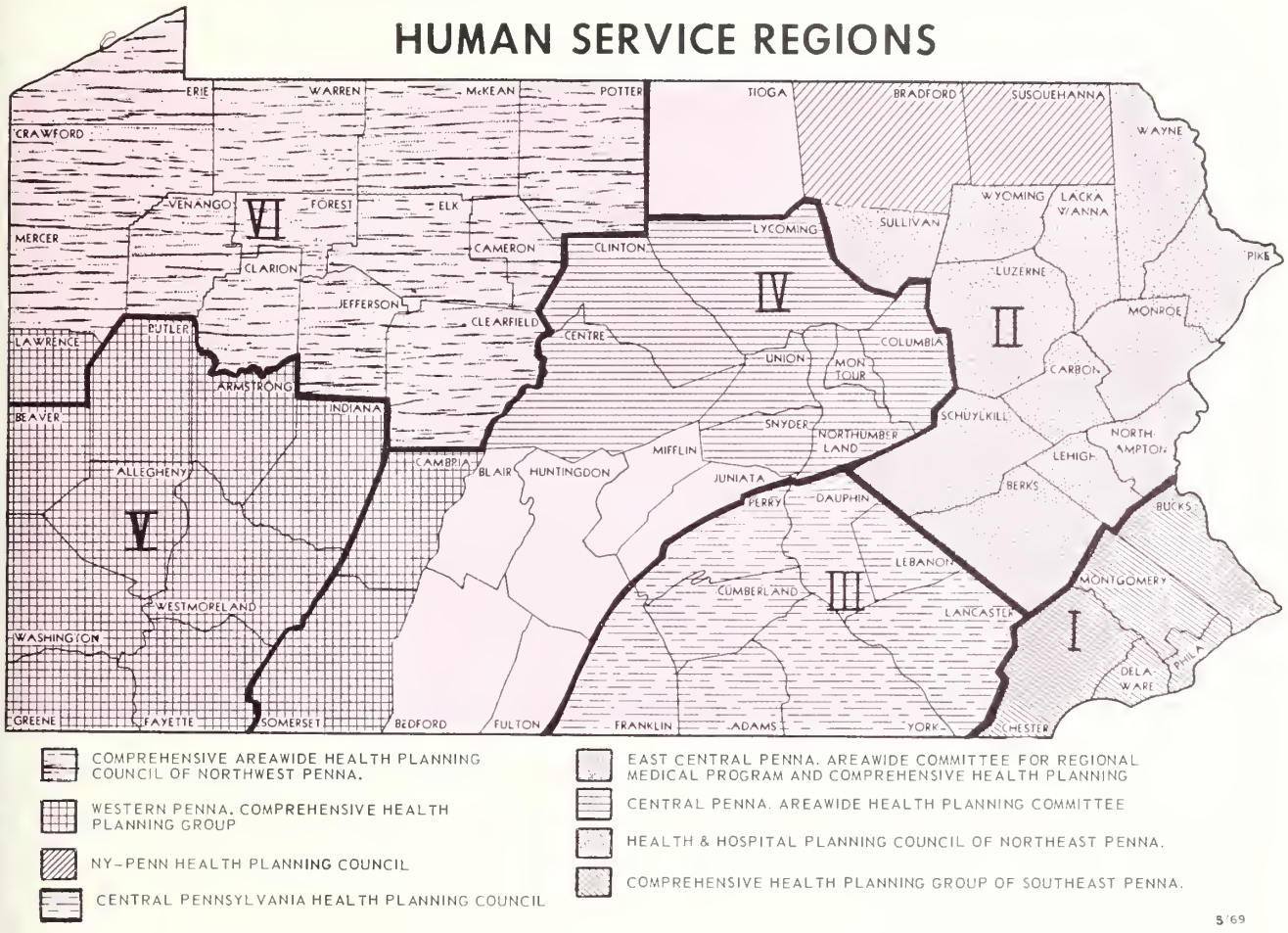
HENRY V. WALKOWIAK, DIRECTOR
Office of Comprehensive Health Planning

Few people question that the present health care system is inadequate. Statistics clearly show that many persons never come to the attention of any member of the health professional team. The situation will not be corrected solely by an increase in the number of health professionals. As the National Advisory Commission of Health Manpower concluded, the crisis in health care will be eased only when the *system* of providing health care is improved.

With the expectation that the system can be changed by comprehensive health planning, Congress passed Public Law 89-749 in 1966 designating funds for both state and regional comprehensive health planning. In Pennsylvania the state Office of Comprehensive Health Planning was established in April, 1968. The office, when staffed with planning consultants, statisticians and a sociologist, will prepare an annual state program based on studies of all existing and potential health services, facilities and manpower.

Health services include health education to the poor as well as rehabilitation clinics, health facilities include sewage treatment plants as well as hospitals, and health manpower includes food inspectors as well as doctors, dentists and nurses. A study of the data in the annual report will answer the ques-

EXISTING OR PROPOSED AREAWIDE COMPREHENSIVE HEALTH PLANNING AGENCIES



tions: What is the chief killer in each age group? What health services are lacking? What areas have higher rates of disease? The law on comprehensive health planning removed the categorical restrictions on the use of federal health funds and the state can now respond more easily to the data with new programs.

Advisory Council

Establishing health priorities for the state is the responsibility of the Advisory Council for Comprehensive Health Planning, appointed by Governor Shafer in 1968 in accordance with the law. In its first year of meeting, the Advisory Council approved the application of four regional agencies to conduct comprehensive health planning, adopted a position paper on contractual agreements for the regional agencies, and appointed chairmen of nine task forces.

A group of twenty-five men and women, the council includes representatives of the home, voluntary health agencies, hospitals, governmental agencies, the state legislature, health professions, health insurance, industry and the communications media. As required by the Partnership for Health Act, the majority of council members are consumers.

As providers, six doctors of medicine are members of the Council. They are state Secretary of Health Thomas W. Georges, Jr., M.D., an ex-officio member; Ellsworth R. Browneller, M.D., administrative director, Geisinger Medical Center, Danville; Donald J. Ottenberg, M.D., medical director, Eagleville Hospital and Rehabilitation Center, Eagleville; Joseph Adlestein, M.D., deputy secretary for mental health, state Department of Public Welfare; and James Z. Appel, M.D., Lancaster, member of the National Advisory Committee on Health Facilities and former president of the American Medical Association.

Under the direction of Dr. Appel the task force on personal health services will study coordination among services and facilities; the availability of facilities, manpower and services; and the kinds of health care wanted and needed. The other task forces will study health costs and financing, health information, planning coordination, health manpower, data collection and retrieval, health facilities, and regional needs and services, and environmental health services.

Future responsibilities of the Advisory Council include reviewing the financing of all health programs, recommending to the state secretary of health ways of improving statewide planning for health services, and promoting and evaluating the development of a sound state comprehensive health program. The council also will continue to review the applications of regional groups to the U.S. Public Health Service requesting funds to organize and operate agencies of comprehensive health planning.

Areawide Planning

Eight agencies of comprehensive health planning today encompass nearly all of Pennsylvania. Each agency is the focus of an area's efforts to assure

Reviewing *the activities of the Southeastern Pennsylvania Regional Comprehensive Health Planning Committee are three Advisory Committee members seated, left to right, William F. Beyer, M.D., Chairman Benjamin S. Loewenstein and John L. Steigerwalt, M.D., vice chairman for Montgomery County. Standing is Richard D. Warfield, executive director of the Committee.*

The development *of areawide comprehensive health planning is being discussed by, left to right, Wesley E. Gilbertson, state deputy secretary of Health for Environmental Protection; and two Advisory Council members. Donald J. Ottenberg, M.D., medical director, Eagleville Hospital and Rehabilitation Center, Eagleville; and Mrs. Catherine B. Bauer, St. Marys.*

"the highest level of health attainable for every person" through comprehensive health planning. By coordinating the planning activities of all health-concerned groups and organizations, the areawide agencies aim to effect a more efficient and adequate health care system.

Two areawide agencies in Pennsylvania currently are organizing for operation under a grant from the U.S. Public Health Service and matched funds from local sources. When the agencies are operational, expected by 1971, they will coordinate the planning activities of health groups, societies, and institutions in their areas.

Though the agencies are encouraged to contract with existing organizations to conduct physical and program planning, they have the primary responsibility for conducting comprehensive health planning. If any aspect of health planning is not being conducted, the areawide agency is expected to conduct this planning.

Other responsibilities of the areawide agencies include (1) recommending planning priorities to institutions, organizations, agencies or groups of the area for short and long-range programs (2) recommending policies for improving the system of providing health services (3) reviewing applications for federal funds for capital construction programs and (4) gathering and analyzing data on the characteristics and health problems of the area's population.

In Pennsylvania the two organizing agencies are located in the southeast and northeast. The Southeastern Pennsylvania Regional Comprehensive Health Planning Committee includes Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties. As part of the development of an operational agency, the Committee is forming task forces and holding open county meetings. The staff of the committee includes an executive director, a planning associate, and two community workers.

Organizing in the northeast is the New York-Penn Health Planning Council, which uniquely comprises two counties in Pennsylvania, Bradford and Susquehanna, and two counties in New York, Tioga and Broome. With a staff of three, an executive director and two planning associates, the Council is acquainting the public with the agency and assessing health problems in the area.

Awaiting approval of funds from the

U.S. Public Health Service are two other agencies, one of twelve counties in the Pittsburgh area, and the other of six counties in the Greater Lehigh Valley area. Another four agencies are drafting applications for approval by the state Advisory Council for Comprehensive Health Planning before submitting them to the Public Health Service. (see map).

The profession of medicine is well represented on the boards of directors of the areawide agencies. Kenneth M. Schreck, M.D., director of medical education, St. Joseph's Hospital, Reading, chairs the areawide agency in the Greater Lehigh Valley area. Serving as vice-chairman of the Southeastern Pennsylvania Committee is John Steigerwalt, M.D., former president of the Montgomery County Medical Society. In addition to these doctors, more than twenty others are members of the seven agencies' boards of directors.

Planning Responsibilities

Comprehensive health planning answers the need for a unified health policy. Health services have sprung up from a myriad of directions—hospitals, neighborhood centers, Office of Economic Opportunity programs, Children's Bureau, and Appalachia funding. Coordinative planning is a requisite to eliminating the duplication of programs that senselessly are consuming the valuable time of health professionals. The office will help to coordinate plans of health projects that are sponsored by federal agencies, as the Office of Economic Opportunity, the Children's Bureau, Public Health Service, and Regional Medical Programs. The office does not channel funds for the projects.

No longer can a person, group or organization plan individually without consultation or concern with another's program. Each person's work relates to another. The doctor will treat a child's rat bite, but the sanitarians direct removal of the garbage on which the rats feed. The hospital nurse will care for the child and a visiting school teacher will instruct him until he returns to class. The doctor, the nurse, the sanitarians and the teacher together have responsibility for the child's health. The purpose of the comprehensive health planning process is to interrelate the environmental, physical, mental and socioeconomic aspects of health.

Emotional Factors in Cardiovascular Disease

Part III

■ **William G. Leaman, Jr., M.D. questions Abraham J. Twerski, M.D., Clinical Director, Department of Psychiatry, St. Francis Hospital, Pittsburgh, Pennsylvania.**

Many cardiac patients who are smokers claim that stopping will increase their nervousness. How should this be handled?

Widespread cardiac involvement in a patient most certainly warrants abstinence. These patients should discontinue smoking promptly and completely and be helped with supportive psychotherapy and ataractic medication. The sense of accomplishment of overcoming the habit should be fully exploited. In those patients whose activities are completely restricted, complete withdrawal may be delayed until return to some activity is allowed since agitation resulting from total abstinence is of extreme severity.

Should the use of alcohol in C-V patients be encouraged or discouraged?

If the patient uses alcohol sensibly and in moderation, there is no reason to restrict alcohol. However, the use of alcohol should not be encouraged in any patient as a tranquilizer, since its use as such may lead to habituation.

What are the psychologic reactions to open-heart surgery?

In the immediate post-operative phase, acute brain syndromes with hallucinations and hyperactivity have been reported. The more prolonged reactions are generally similar to those encountered following severe myocardial infarction, and there are studies currently underway to evaluate the long-term adjustments. One advantage the surgical patient has over the infarct patient is that the former may be evaluated pre-operatively and psychologically and prepared for surgery and its sequelae.

Does prolonged inactivity have an adverse effect?

Marked restrictions in activity, e.g., work, social life, sexual relations, can lead to adverse emotional reactions. When restrictions are necessary, they should be prescribed with full recognition of these "side effects". Physicians are quite familiar with the "cardiac cripple" whose regression to a state of dependency may, at times, be iatrogenic. Whenever possible, encourage a return to normal living to minimize these negative reactions.

How much should the family know of the patient's illness?

Always take time to explain the patient's condition to those closest to him. Working together with the family to adjust realistically to the patient's illness and his recovery is a vital part of treatment.

When should "therapy" with the family begin and who should be the therapist?

The attending physician is the most effective therapist. Work with the family should begin immediately since their attitudes, whether overt or covert, can be determining factors in the patient's recovery. For example, the unspoken attitude of despair of the family of a stroke patient, who may feel that the patient will now be a burden upon them, may delay the rehabilitation. Convincing the family at the outset that the patient can eventually be restored to independent function will lead to their participation and aid in recovery.

Should the attending physician work alone with the parents of a child with rheumatic fever or congenital heart disease?

In any case, child or adult, when the emotional problems appear to be beyond the realm of the attending physician, consultation should be obtained and referral for treatment should be made when indicated. With children especially, the effects of heart disease on the developing personality, possibly complicated by the guilt-ridden or overprotective attitude of the parents, are of sufficient magnitude to warrant guidance for the parents by qualified child psychiatry personnel. By working in close collaboration with the physician this should help the emergence of a less distorted personality.

How can non-psychiatric physicians increase their competence to deal with the emotional problems involved in cardiovascular disease?

Unfortunately, this aspect of medicine is often inadequately stressed in the training of the physicians, and its importance may not strike the newly emerged doctor who is still enamored of the technology of modern medicine. Exposure to treatment of the patient in his natural habitat will soon make him aware of the need for increased efficiency in dealing with emotional components of illness. Many teaching institutions have courses on the psychologic factors in illness, and physicians should avail themselves of these whenever possible.

■ **William G. Leaman, Jr., M.D., Fellow, Council on Clinical Cardiology of the American Heart Association, edited this brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.**

Let's be specific about Campbell's Soups... and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

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and attention he requires.
She needs time for her husband...
and for herself as well...
so that she can come to terms
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It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

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Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Orol contraception.

Contraindications—Thrombaphlebitis, thromboembolic disorders, cerebral opoplexy or a past history of these conditions, morkedly impoired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplosia, undiognased abnormol genital bleeding.

Warnings—Wotch far the earliest monifestotions of thrombotic disorders (thrombophlebitis, cerebrovosculor disorders, pulmonary embalism, retinal thrombosis); if present or suspected discontinue the drug immediotely.

British studies reported in April 1968[1,2] estimote there is o seven- to tenfald increase in mortality and morbidity due to thromboembolic diseases in wamen taking arol contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitolizations due ta "idiopothic" thromboembolism, statistical evaluotian indicated that the differences observed between users ond non-users were highly significant. The canclusions reached in the studies ore summarized in the table below:

Comporison of Mortality ond Hospitolization Rotes Due to Thromboembolic Diseose in Users and Non-Users of Oral Controceptives in Britain.

Categary	Mortality Rates		Haspitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies ore yet avoilable in the United States. The British data, especially os they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to wamen in ather countries in which the incidences af spontaneously occurring thromboembolic disease moy differ.

Discontinue medication pending examination if there is sudden partial ar complete loss af vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if popilledemo or retinol vascular lesions are faund.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recammended thot pregnancy be ruled aut for ony patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient hos nat adhered ta the prescribed schedule the passibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in orol contraceptives hos been identified in the milk of mothers receiving these drugs. The long-ronge effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physicol exominotian should include speciol reference to the breosts ond pelvic organs, and o Popanicoloou smeor.

Endocrine ond possibly liver function tests moy be affected by Ovulen. Therefore, it is recammended that such tests if obnormol be repeoted after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas moy increose in size under the influence of progestogen-estrogen preparations.

Because these agents moy couse some degree of fluid retention, conditions which might be influenced by this foctor, such os epilepsy, migroine, asthmo, cordiac or renol dysfunction, require coreful observotion.

In breakthrough bleeding, and oll irregulor voginol bleeding, consider nanfunctional couses. Adequate diognostic meosures are indicated in undiognosed vaginal bleeding.

Carefully observe patients with a history af psychic depressian and discontinue the drug if severe depressian recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, odrenal, hepatic or uterine function awaits further study.

A decrease in glucase tolerance has occurred in a significont percentoge of patients on oral contraceptives. The mechonism of this decrease is obscure. For this reason, diobetic patients should be observed corefully while receiving Ovulen.

Becouse of the effects of estrogens on epiphyseal closure Ovulen shauld be used judiciously in young potients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy moy mosk the onset of the climacteric.

The pathologist should be infarmed of Ovulen theropy when relevant specimens are submitted.

Adverse Reactions—A statistically significant associatian hos been shown between use of aral contraceptives and the following serious odverse reoctions: thrambophlebitis, pulmonory embolism.

Although ovoilable evidence is suggestive of on ossociation, such a relationship has been neither confirmed nor refuted for the following serious adverse reactians: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and aptic neuritis.

The following adverse reactians are known to occur in patients receiving aral cantroceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flaw, amenorrheo during ond after treatment, edema, chlaasma or melosma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretians, suppression af lactotion when given immediately past partum, chalestatic jaundice, migraine, allergic rosh, rise in blaod pressure in susceptible individuals, mentol depression.

Althaugh the following odverse reactions have been reported in users af orol contraceptives, an associatian has been neither confirmed nor refuted: onovulotion post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemarrhagic eruptian, itching. The following laboratory results may be oltered by aral contraceptives: hepatic function: increased sulfabramaphthalein and other tests; coagulation tests: increase in prothrambin, Foctors VII, VIII, IX and X; thyroid function: increase in PBI and butanal extractable protein bound iadine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

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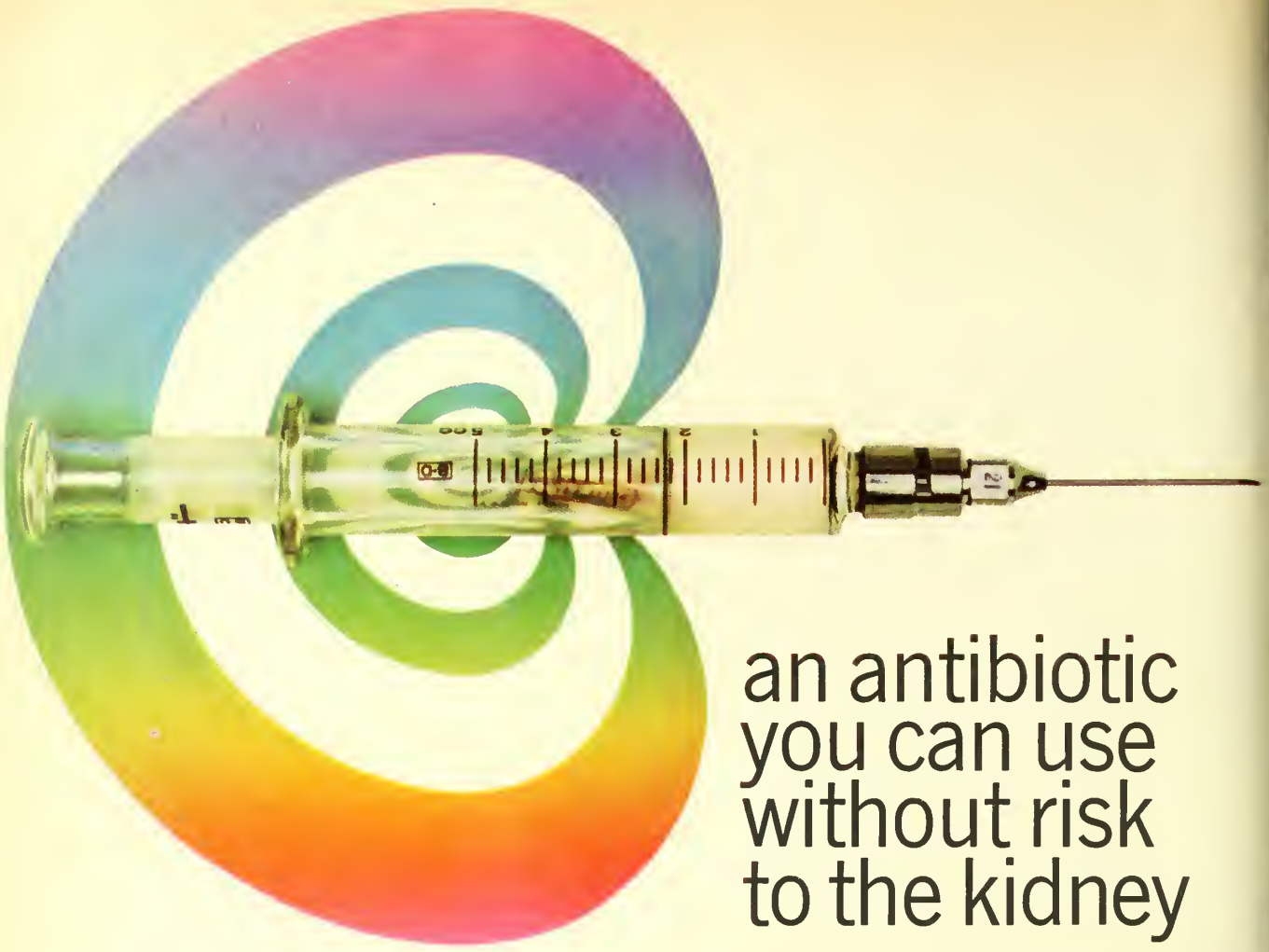

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Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

A.H.F.S. Category 8:12.16

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Summary of

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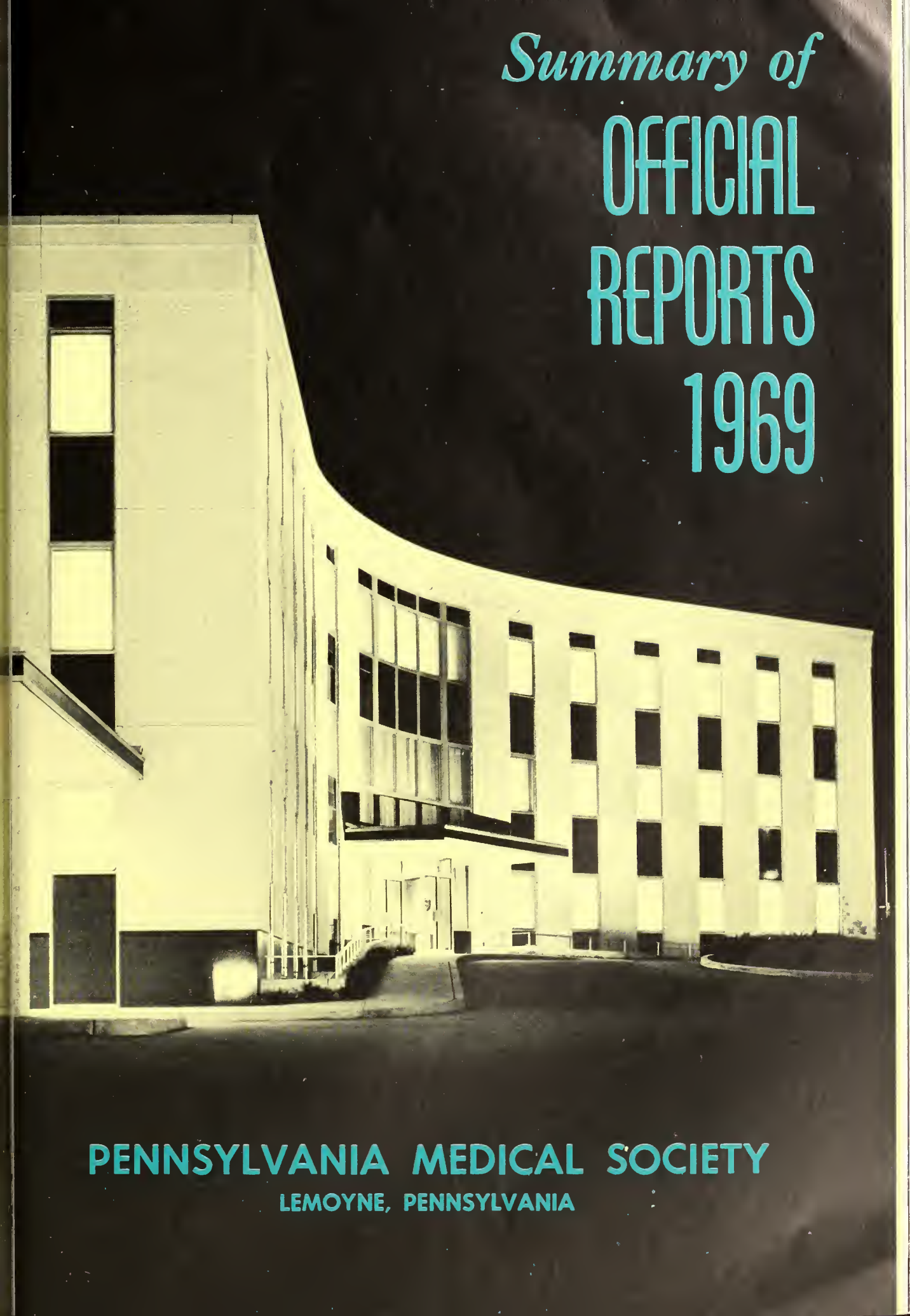

PENNSYLVANIA MEDICAL SOCIETY
LEMOYNE, PENNSYLVANIA

SUMMARY 1969 REPORTS

PENNSYLVANIA MEDICAL SOCIETY

All items appearing in this special section of PENNSYLVANIA MEDICINE are summarizations of the 1968-1969 annual reports. Complete annual reports, including the Auditor's Report, are included in the *Official Reports to the House of Delegates* booklet, copies of which are available upon request.

BOARD OF TRUSTEES AND COUNCILORS

William A. Limberger, M.D.

This report summarizes significant actions taken by the Board of Trustees during the 1968-69 year, as outlined in the Board's Annual Report.

The Board:

- Appropriated funds for a survey of the entire membership on malpractice insurance.
- Approved a model group malpractice insurance program developed by the Council on Medical Service. The Council is currently exploring the possible implementation of this program with several insurance carriers.
- Approved the development of a long-range legislative program to alleviate the malpractice situation, along the lines of legislation recently sponsored by the California Medical Association.
- Urged the Insurance Commissioner to seek ways to encourage carriers to liberalize their underwriting policies and to consider the establishment of an assigned risk program for physicians who are unable to secure coverage, similar to the program in effect for automobile insurance.
- Directed the Council on Governmental Relations to explore with the Pennsylvania Bar Association the possibility of organizing medical-legal arbitration boards which would serve as the initial step in processing malpractice actions.
- Established a revolving fund within the Educational and Scientific Trust to finance the expanding educational activities of the Council on Education and Science. An initial contribution of $10,000 was made to the Trust by the Society for this purpose.
- Authorized the Council on Education and Science to apply for funds from the regional medical programs in Pennsylvania in order that it may prepare educational programs on heart disease, cancer, stroke and related diseases.
- Authorized the provision of administrative services by the Society to specialty societies in return for reimbursement for the cost of these services.
- Adopted a policy that Blue Cross and Blue Shield underwrite coverage for all Title XIX Pennsycare beneficiaries, the Department of Public Welfare to assume the cost of the necessary premium.
- Authorized a special group comprised of the president, president-elect, chairman of the board, and chairman of the Special Committee to Study Relations Between Medicine and Osteopathy to meet and discuss mutual problems with representatives of the Pennsylvania Osteopathic Society.
- Authorized the administrative councils to invite SAMA representatives to their meetings.
- Endorsed SAMA's program to provide summer rural practice experience for medical and nursing students and authorized the staff to cooperate with SAMA in implementing this program by finding preceptors and in other appropriate ways.
- Determined to urge continuation of the higher education assistance program of scholarships and loans for medical and paramedical students and restoration of the $26,000,000 item originally planned in the Federal budget for this purpose.
- Directed the President and appropriate staff to meet with the Governor to present a position paper requesting that the Governor improve the status of the Commonwealth's Department of Health, including a description of the health matters which should be under the Department's jurisdiction and an endorsement of the concept of decentralization of health and welfare services through the establishment of regional authority for decision-making.
- Authorized the Chairman of the Council on Medical Service to write to the Appropriations Committee of the House of Representatives outlining the Society's concern with respect to upgrading the health care of Pennsylvania's needy citizens.
- Rescinded its previous actions supporting the licensure of paramedical personnel and approved a recommendation that the State Board of Medical Education and Licensure consider certification of paramedical personnel through the use of national certification programs in place of licensure. For further details on this, see the report of the Council on Education and Science.
- Endorsed the plan calling for merit selection of judges submitted to the electorate in the May 20, 1969 Primary Election and approved a letter to the membership urging a vote in favor of this plan.
- Determined to support the continuation and expansion of the Medical Library Assistance Act.
- Determined not to accept advertising for clinical laboratory services by commercial laboratories until such time as advertising of professional medical services becomes the uniform policy of the medical profession. Urged the AMA to reconsider its acceptance of such advertising.

SECRETARY

Allen W. Cowley, M.D.

During the past year, I have continued to consult with the administrative staff of the headquarters office concerning details with regard to the responsibilities of the Secretary's Office. This includes such areas as medical defense, medical benevolence, signing of official documents, etc. I have attended the regular meetings of the Board of Trustees and the Committee on Medical Benevolence.

The secretary's office has communicated with many county medical societies regarding grievances submitted to the headquarters office and, in cooperation with legal counsel of the Pennsylvania Medical Society, has provided legal opinions to county medical societies and individual physicians.

JUDICIAL COUNCIL

The Judicial Council convened in Philadelphia in January to hold two hearings and consider several other items of business. The first hearing was called at the request of the Philadelphia County Medical Society and concerned certain ethical questions raised by members of the medical staff of the Albert Einstein Medical Center. In the course of rendering its opinion on this matter the Judicial Council outlined certain "Guidelines for Hospital Medical Staffs." Copies of these "Guidelines" and the council's opinion are available to members of the House from the headquarters office upon request.

The second hearing concerned certain ethical questions raised by the medical staff of the Lankenau Hospital with respect to relations between the medical staff and the hospital administration and was called at the request of the Delaware, Montgomery, and Philadelphia County Medical Societies. Copies of the opinion resulting from this hearing are also available upon request.

Resolution 67-9: Unjustified Restriction of Hospital Privileges

Resolution 67-9, "Unjustified Restriction of Hospital Privileges," which was adopted in amended form by the 1968 House of Delegates, outlines appeal procedures for Society members who are aggrieved as a result of action on the part of lay governing boards of hospitals. This resolution was brought to the attention of Council members for their information and future reference.

Resolution 68-13: Fee for Service

Resolution 68-13, "Fee for Service" was referred to the Judicial Council by the 1968 House of Delegates for study and review. The "*Resolved*" portion of this resolution states the following:

> "*RESOLVED*, That the Pennsylvania Medical Society declare it to be unethical for a physician to submit or to collect a fee for medical, obstetrical, or surgical service unless the physician is personally present when the service is rendered."

The Judicial Council concurs with the intent and spirit of this resolution. However, the Council feels that the requirement that a physician be "personally present" is somewhat stringent and unrealistic in this modern day and age. For example, a physician who has direct supervision of interns and residents may spend a significant amount of time diagnosing a case and advising with regard to its treatment, even though he may not be present during the entire period when the treatment is provided. Similarly, we all know that after a physician diagnoses an illness he may in many instances not be present for all phases of its treatment, some of which may be carried out by paramedical personnel under his direct supervision. A final example is a data-phone over which electrocardiographic data may be transmitted over long distances via telephone wires to a cardiologist. In this situation the cardiologist provides an important service, although he most certainly is not present at the patient's side.

For the above reasons, the Council believes that the "*Resolved*" portion of this resolution should be amended as follows:

> "*RESOLVED*, That the Pennsylvania Medical Society declare it to be unethical for a physician to submit or to collect a fee for medical, obstetrical, or surgical service unless the physician personally provides or personally supervises the service rendered."

The Judicial Council recommends that the House adopt Resolution 68-13, amended as suggested above.

Resolution 68-25: Discrimination

Resolution 68-25, "Discrimination," called for the Society to request that the AMA clarify the term "repeated violations" as it applies to medical associations which deny membership to applicants because of creed, race, religion or ethnic origin. This resolution was referred to the Judicial Council by the Board of Trustees.

At its meeting in Miami in December, 1968, the AMA House of Delegates considered Bylaw amendments to Chapter XI, Section 11, (D), which outlines the functions of the Judicial Council of the AMA. This resulted in the adoption of the following amendment to paragraph 7 of subsection (D) (amendment underlined):

> "(7) The Council shall have jurisdiction to receive appeals filed by applicants who allege that they, because of color, creed, race, religion or ethnic origin, have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. *If the Council determines that the allegations are indeed true, it shall admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association.*"

In considering this action by the AMA House of Delegates, it was evident to the PMS Judicial Council that the term "repeated violations" was not clarified. The only way to clarify it would be to state specifically the number of violations that would be countenanced.

However, the power to determine "repeated violations" has been vested in the Judicial Council of the AMA, and in the Council's opinion this is the proper place for such authority. Furthermore, the intent of the AMA House of Delegates with regard to "repeated violations" is clearly

reflected in the Bylaw amendments. The Council believes that the AMA Judicial Council should be permitted to exercise some discretion in formulating its judgments and in implementing the intent of the AMA House, and not be bound by completely rigid criteria. It is the opinion of the Society's Judicial Council that this confidence in the Judicial Council of the American Medical Association is well-justified by its past performance.

For all of the above reasons, the PMS Judicial Council determined that the action taken by the AMA House of Delegates with regard to discrimination was sufficient, and that no further action on the part of the State Society is warranted at this time. The Board of Trustees has concurred in this conclusion.

MEDICAL DEFENSE

During 1968, six applications for medical defense were filed and approved. During the same period, eleven medical defense cases were closed. The total expenditure for legal fees from the Medical Defense Fund in 1968 was $2,322, leaving a balance of $107,938 in the fund. For further comments on the Fund's status, see the Report of the Treasurer.

As of May 31, 1969, there were forty-three active medical defense cases in our files. By Councilor Districts these are as follows: First—9, Second—16, Third—2, Fourth—2, Fifth—1, Sixth—0, Seventh—1, Eighth—0, Ninth—0, Tenth—10, Eleventh—1 and Twelfth—1.

In seventeen of the cases listed above, the physicians do not carry malpractice insurance.

CONCLUSION

I have served as secretary of the Society since 1963. The years have been filled with many memorable experiences and it has been both a privilege and an honor. In this, my last year of service, I wish to express my appreciation and thanks to the House of Delegates for this opportunity.

EXECUTIVE DIRECTOR

Lester H. Perry

During the past year the Society began an experiment in cooperation with a specialty group which, if successful, could result in more unified action by organized medicine in Pennsylvania. In 1968, the Board of Trustees adopted a broad-based policy to provide administrative services to all interested specialty societies in return for reimbursement to cover the administrative costs. The Board believes that such a policy has the potential of creating closer understanding and coordination between the Pennsylvania Medical Society and the specialty societies. Since services are provided on a reimbursement basis and policy direction is provided by the specialty group, no loss of autonomy is involved.

In December of 1968, we began to provide administrative services to the Pennsylvania Psychiatric Society, originator of the proposal. A portion of the time of a member of our staff and his secretary is assigned to provide these services in accordance with the agreement. Thus far the arrangement has produced no unusual difficulties or problems and has functioned to the satisfaction of both parties involved.

On the surface it might appear that this kind of arrangement, which involves cooperation between two policy making bodies, invites trouble. But our administrative structure is flexible enough to overcome the difficulties involved. Policy direction is provided by the Psychiatric Society, and the assigned staff man carries out these policy directives. He receives administrative guidance through our executive reporting structure. What he does is determined by the appropriate policy makers—in this case the Pennsylvania Psychiatric Society. How he does what he is directed to do is our administrative responsibility. The clear distinction between what is policy responsibility and what is an administrative responsibility is the key that makes this arrangement workable. An understanding of this distinction, incidentally, is the foundation upon which most successful ventures in association management are built.

The House of Delegates and the Board of Trustees have taken literally hundreds of actions during the past year which required study and implementation by staff. All the actions taken by the House of Delegates—which total approximately one hundred—have been or are now being implemented. In carrying out these decisions, I have encouraged the staff to respond to the spirit as well as the letter of these actions in order to assure that each receives its proper measure of attention. Following its implementation, each action is reviewed again to make certain that everything possible has been done to accomplish its purpose. The annual reports of the Board of Trustees, the councils, and the committees reflect many of the details involved in the fulfillment of these policy decisions.

The Society's administrative responsibilities have broadened extensively over the last several years. This is best exemplified by the Society's fiscal and administrative responsibility for the Susquehanna Valley Regional Medical Program. In addition, as previously mentioned, the Society has begun providing administrative services to a specialty society. The Society now employs fifty-six persons, including eighteen staff members who are assigned to the Susquehanna Valley Regional Medical Program and whose salaries are wholly reimbursable by the Federal Government. This figure represents an increase of one staff member for SVRMP since my last annual report. During the past year, SVRMP has launched the operational phase of its program, but planning activities nevertheless will be continued.

Richard L. Sloan, executive assistant to the Council on Medical Service, requested and was granted a leave of absence because of illness. The nature of his illness makes it unlikely that he will be able to resume his work on a full-

time basis. His many friends on the staff and among the membership miss the presence of his keen mind and quick wit. Applicants are currently being interviewed in order to bring the staff assigned to this council up to full complement.

In completing my thirty-fifth year of service with the Society and my last as executive director, perhaps my biggest job was to prepare the members of the staff for the transition. I have endeavored to accomplish this goal in several ways. First, I encouraged the Board of Trustees to designate my successor early in order to give everyone concerned ample time to adjust to the knowledge of this change. Secondly, during the past year I have been gradually turning over more and more responsibilities to my successor, John F. Rineman, who is currently assistant executive director. He in turn has reassigned accountabilities for which he has been responsible to other staff members. As a result, these staff members have also had the opportunity to acquaint themselves with their new responsibilities.

An important part of my job is to use the talent and ability of the staff to meet current needs. Perhaps even more important, however, is the challenge of preparing my colleagues for the responsibilities of tomorrow. Since the human resources of an organization are among its most valuable assets, I have devoted significant efforts toward this end. The less my absence is noted after my retirement, the more successfully will I have achieved this objective.

Dues statements for the current year were again prepared by means of data processing equipment for fifty-seven county medical societies, which sharply reduced the time required by these societies for this function. This service is offered to all component societies. For this reason, the Membership Department has developed an extremely flexible dues statement form to accommodate most of the variables which could conceivably occur among the sixty county medical societies. These statements can be mailed directly from the Pennsylvania Medical Society to the member if desired by the component society. In 1969, thirty-seven county medical societies chose to have the State Society provide this service. The only charge to the county societies was for postage.

During 1968, the Society experienced a decline in the number of members who pay full dues (from 10,733 to 10,670), but there was an increase in total membership (from 12,233 to 12,301). The Society attracted 407 new members in 1968.

The membership has been responsive to the growing changes in PENNSYLVANIA MEDICINE over the past few years. As a result, the publication has assumed an increasingly important role as the medium for communicating not only scientific and educational information but also socioeconomic, political, and organizational news of interest to our members.

Changes in editorial policy and the appearance of the publication have enhanced reader appeal. The addition of an associate medical editor has distributed the editorial burden more evenly. In late 1967, the supervision of the staff of PENNSYLVANIA MEDICINE was transferred to the executive assistant to the Council on Public Service so that the publication would profit by additional years of experience in the communications field. This new blend of staff talents has been reflected in the quality of the publication.

The addition of David A. Smith, M.D., of Harrisburg, as associate medical editor became necessary because of the increasing number of original scientific papers submitted for publication and because of the need for an immediate local source of medical reference for the managing editor. Dr. Smith has already proven his value in reviewing manuscripts, writing editorials, and providing technical assistance in the preparation of illustrations for articles in addition to being the day-to-day authority in the interpretation of medical terminology.

The mailing list for PENNSYLVANIA MEDICINE was recently subjected to a critical review in order to eliminate unnecessary complimentary subscriptions. That process has made it possible for us to supply a complimentary subscription for the intern-and-resident lounge of every accredited hospital in the Commonwealth, where we hope it will make new friends for organized medicine.

Printing costs have declined more than 5 per cent as the result of a system of annual competitive bidding by area printers for the production of the Journal. Despite an increase in advertising rates effective in July, 1968, revenue from this source remained at approximately the same level as in 1967. The reason for this lies in the fact that advertising volume declined in 1968. However, advertising revenue for the first six months of 1969 is ahead of last year's pace.

We are currently in our third year of operation at the new headquarters located in Lemoyne, Pennsylvania, just across the Susquehanna River from Harrisburg. In addition to our own meetings, the headquarters building has served during the past year as the location for a meeting of a county medical society, for several committee meetings of the Pennsylvania Psychiatric Society, and for examinations conducted by the State Board of Medical Education and Licensure. Its convenient location, ample parking space, and modern equipment make it an ideal facility for such purposes.

Last year, the House of Delegates and the Scientific Assembly were convened separately in accordance with the decision made in 1967. The administration of two separate meetings instead of one integrated convention, as in the past, caused no particular difficulty.

As I prepare this report, plans for the meeting of the House of Delegates in Philadelphia are moving forward under the coordination of the assistant executive director. This year, the Scientific Assembly will be held at the Host Farm Motel in the resort area of Lancaster County—a departure from the practice of holding these meetings in either Philadelphia or Pittsburgh. The administration of the Scientific Assembly has been assigned to the staff of the Council on Education and Science since that council has assumed the responsibilities formerly carried out by the Committee on Convention Program. We anticipate the Scientific Assembly will require the assistance of more members of the staff this year since we are unable to utilize convention bureau personnel as we do in Philadelphia and Pittsburgh. However, we expect no significant problems at either meeting.

As I conclude my last annual report, I wish I had the ability to express adequately all that should be said, but no brief sketch could encompass the change and the struggle and the progress experienced by this organization over the past thirty-five years.

In a position such as mine sometimes the pathway seems arduous, but the rewards are rich indeed. Perhaps the greatest reward of all is the friendship of scores of men and women in the noble profession of medicine.

Some of these friends I don't see very often, but the true quality of a human relationship is not measured by

the frequency with which people get together. Rather, it is measured by the mutuality of interest which binds them together. It is enhanced by their dedication to a common cause and by the ability of each to contribute to the achievement, the happiness, and the welfare of the other.

Judged by these criteria, the best friends I have are in the membership of this Society, the Woman's Auxiliary, and the administrative staff. For this reason above all others, I don't like to say good-bye.

But all journeys, even those which are long and pleasant, must someday come to an end. For the friends I have found on this journey—for the encouragement I have received from delegates, officers, and trustees—for the earnest helpfulness of the Woman's Auxiliary—for the loyalty of my colleagues on the administrative staff—for all these blessings and many more, I am grateful.

TREASURER

Lester H. Perry

The customary examination of the Society's accounts as of December 31, 1968, was performed by Main, Lafrentz and Co., certified public accountants, and the report of their audit is being submitted to all members of the House of Delegates. It is available to others upon request.

The Society's resources are contained in five separate funds. Four of these funds are earmarked for special purposes and are not available for current operating expenses.

The annual assessment of our members who pay full dues was $75 for the year 1968. Of this total, however, only $65 was available to the General Fund for the operating expenses of the Society. By action of the House of Delegates, $10 per member was allocated as follows: $8.00 to the Educational and Scientific Trust for loans and scholarships, $1.00 to the Medical Benevolence Fund, and $1.00 to the Medical Defense Fund.

The General Fund is the active functioning account for the day-to-day operation of the Society's various programs. During 1968, income for this account (derived chiefly from dues, advertising in PENNSYLVANIA MEDICINE, commercial exhibits and registration fees at the convention, and investments) amounted to $903,454. Expenses for 1968 totaled $788,078. With income of $903,454 and expenditures of $788,078, the Society ended the year with a surplus of $115,376 in the General Fund.

The Medical Defense Fund had assets totaling $94,704 at the beginning of the fiscal year. The allotment from dues amounted to $10,879 and the income on investments $5,101 for total income of $15,980. The Fund paid out $2,322 for medical defense purposes and $424 for investment expense for a total of $2,746, which resulted in a net balance of $13,234 for the year, thus increasing the assets of the fund to $107,938 as of December 31, 1968.

Assets in the Medical Benevolence Fund totaled $533,169 on January 1, 1968. The Fund received $10,923 from dues allocations and $28,219 from income on investments. Contributions from the Woman's Auxiliary amounted to $8,521. Gain on the sale of investments of $8,468 brought total income to the Fund of $56,131. Payments to recipients of $39,612 and investment expense of $2,074 left a net balance of $14,445 for the year. This brought the total assets of the Medical Benevolence Fund to $547,614 as of December 31, 1968.

At the beginning of 1968, the Contingency Reserve Fund was valued at $69,400. The Board of Trustees authorized the transfer of $49,106 from the 1967 surplus to the Contingency Reserve Fund. Income on investments was $1,072, but the Fund suffered a loss of $328 on the sale of investments and had investment expenses of $108. These transactions resulted in an increase in assets of the Fund to a total of $119,142 on December 31, 1968. An additional transfer of $75,000 from the 1968 surplus to the Contingency Reserve Fund was authorized by the Board of Trustees on May 14, 1969.

As of December 31, 1968, the Property and Equipment Fund included land and building valued at $761,784 and furniture and equipment valued at $78,009. Reserves for replacement of both the building and the furniture and equipment accounted for $56,215. The mortgage was reduced to $121,380 by the end of 1968. On May 14, 1969, the Board authorized a further reduction—in addition to the regular monthly payments—of $25,000. The total value of the Property and Equipment Fund at the close of the fiscal year was $896,008.

SUMMARY REPORTS OF INDIVIDUAL COUNCILORS

FIRST COUNCILOR DISTRICT

A. Reynolds Crane, M.D.

At a dinner meeting May 15, 1969, a most unusual event in the history of the First Councilor District took place. At that time, William F. Irwin was elected an honorary member of the Philadelphia County Medical Society and at the same time was presented with the Strittmatter Award, the highest award of the Society and the first non-physician of forty-five recipients to be so honored. This tribute to Bill, who is so well-known to physicians throughout the Commonwealth, met with universal acclaim and recognition for his thirty-one years of dedication as executive secretary of the society and as Richard A. Kern, M.D., who presented the award, stated it: "The Committee has reached the happy decision that in the year of 1968 no other person, medical or non-medical, in the orbit of the

Philadelphia County Medical Society so completely embodies all the qualities of service, devotion and achievement in and for the cause of Medicine, envisioned by Dr. Strittmatter, as does William Francis Irwin." Bill officially retired as secretary of the society in July, 1969, and his ever willing and helping hand will be sorely missed at all levels of organized medicine. Appropriately, at the same meeting, fifty year certificates for devoted services to medicine were presented to twenty-two recipients by this Trustee and Councilor.

While the Philadelphia County Medical Society counts the majority of physicians in the area as members, there remains a concern over the non-participants. The Committee on Society Membership and Organization under the able leadership of David S. Cristol, M.D., has addressed itself to this matter and concentrated on the "full-time" physicians and on establishing liaison with local specialty organizations. The Society now numbers 3961 of which 3110 are active members, 346 are associate members and 505 are affiliate members. An active committee under the successive chairmanships of T. H. Mendel, M.D., J. V. Blady, M.D., and P. S. MacNeal, M.D., has been studying the problem of the future of private practice in the light of the growth of full-time institutional based physicians. The Committee on Hospital Affairs under Brooke Roberts, M.D., and George Rosemond, M.D., has also addressed itself to this and other patterns of change in the practice of medicine, particularly requesting that the Joint Committee on Accreditation of Hospitals concern itself with assuring that there will be no abrogation of medical staff rights in accredited hospitals.

The malpractice insurance problem is perhaps the most difficult one facing all physicians, whether or not they are members. The Committee on Medical Economics, under R. R. Tyson, M.D., and J. D. Alexander, M.D., has pursued the insurance aspect and through them, the society has cooperated with the State Society and the Insurance Commissioner in an attempt to alleviate the critical difficulty of proper coverage in certain areas and specialty fields. The society sponsored a special meeting on this subject on Sunday, May 25, 1969, which was addressed by Mr. F. E. Shields, Esquire, Mr. D. R. Lowe of the Medical Protection Company and Mr. J. A. Smither, chief deputy insurance commissioner. In contrast with the difficulties in that field is the accolade earned by W. F. Bouzarth, M.D., when he was presented with the Man of the Year Award by the Amity Square Club for his outstanding work in developing the Philadelphia Regional Emergency Medical Disaster Operations Plan (PREMDOP) as chairman of the Society's Committee on Disaster Medicine which has given the area a well-organized, workable plan proven effective in a trial run this spring. The Professional Relations Committee under G. F. Tucker, Jr., M.D., has continued an effective public relations program promoting understanding between patients and physicians and handling some ninety specific complaints during the year.

The society's activities in the educational area have continued with a successful Post-Graduate Institute under the direction of C. R. Shuman, M.D., from March 31 to April 2, 1969, with excellent practical presentations in the fields of coronary care, gastro-enterologic disorders, rheumatology and cancer therapy. The annual Da Costa Oration was delivered on December 18, 1969, on the subject of cardiac surgery, by P. V. Moulder, M.D. A. N. Brest, M.D., of the Committee on Medical Education earned approval and financial support for a program of "Self-Assessment" by physicians and E. H. McGehee, M.D., is planning the development of methods of assessment. Friends of M. T. Wohl, M.D., who has devoted many years to the activities of the Subcommittee on Nutrition, Metabolism and Endocrinology, have established a fund to make possible a lectureship in his name. Dr. Wohl chaired the 13th Annual Conference on Nutrition and Metabolism in October, 1968. The society acted as host in April to a Nurse-Physician Seminar under the auspices of the Pennsylvania Medical Society, the Pennsylvania Association of Nurses and the Southeastern Pennsylvania League for Nursing. C. M. Thompson, M.D., and J. Helwig, Jr., M.D., served as co-chairmen. A joint task force with the Delaware Valley Health Council and the Blue Cross of Philadelphia is studying the costs of medical care with a view to increasing efficiency and producing more care for the health care dollar. R. G. Gill, M.D., and J. Z. Appel, M.D., fielded questions in a "Hot Wire" radio program held on July 15, 1968, deftly coping with a broad range of questions from the listening public.

The Woman's Auxiliary under Mrs. J. Stauffer Lerman, and subsequently Mrs. J. Antrim Crellin has continued to make incredibly effective and creative contributions to medicine and the community. The Auxiliary's Health Substitute and Health Career activities have enriched the knowledge of the general public in these areas. Its fund raising activities have contributed $1000 to the Aid Association, $500 to the Physick House, and $700 to scholarship aid for nurses. Mrs. Axel K. Olsen of our auxiliary now serves as forty-fifth president of the Pennsylvania Medical Society Auxiliary. The thirty-ninth annual Health Institute held at the Society building included such topics as Home Centered Health Care, The Generation Gap and Sex Education and was well attended and received.

The society continues its attempts to reach out to the community and has again sponsored a Greater Philadelphia Health Fair to be held at the Philadelphia Civic Auditorium, October 9-13, 1969. Malcolm Miller, M.D., who was responsible for the great success of last year's fair, again serves as chairman. The society is providing "spot" educational announcements with questions and answers on topics of current interest and broadcast over Radio Station WIP. Community Health week, featured October 20-26, 1968, at the society building and well planned by P. B. Storey, M.D., brought together health education exhibits of various voluntary health agencies. The Committee on Community Medicine has been actively interested in the development of various health centers. Plans to emphasize the role of the practicing physician in community health in its broadest aspects are well developed, as is an effort to have this aspect of medical care given better coverage in the medical school curriculum. The society is represented in the Model Cities program. E. L. Housel, M.D., serves as chairman of the Medical Co-ordinating Committee of the Philadelphia Bicentennial Committee. In a further effort in community affairs, T. H. Mendel, M.D., and W. F. Bouzarth, M.D., testified at a public hearing urging improved re-imbursement to all hospitals for their Emergency Out-Patient Services.

In the area of community services, the society serves as an advisor to the Philadelphia Red Cross Blood Program. The society also has under consideration a mass immunization program against rubella. Air pollution continues as one of our most pressing problems and Past

President Katherine Sturgis, M.D., has zealously pursued numerous avenues to attempt to effect a productive program of control through the Department of Health. *Philadelphia Medicine*, under the discerning editorship of Donald Geist, M.D., continues to be both an interesting publication and a source of information, not only about the affairs of the county society, but also about medical activities throughout the district, state and nation. Any member who reads it is well informed of the efforts of organized medicine for the public good at all governmental levels as well as of the efforts to prevent the placing of additional fetters about practitioners of medicine. Members who do not read it have no excuse for being uninformed or misinformed.

The year has been an unusually productive and stimulating one, under the leadership of Katherine Sturgis, M.D., our president, who was succeeded by Theodore H. Mendell, M.D. These leaders have not only given freely of their own time to the affairs of the society, the community, and the public, but also have persuaded many others to do so as well. I have been able to mention only a few of these. Under their leadership it has been a year of distinguished service by and for the First Councilor District.

There are no items in this report requiring action.

SECOND COUNCILOR DISTRICT

William A. Limberger, M.D.

BERKS COUNTY

Another famous clam bake, masterminded by John Focht, M.D., ushered in the September meeting of the society.

"Physician-Nurse Cooperation and Coordination in State and Federal Programs" was the subject discussed by Mrs. Betty Bankes, executive director, Visiting Nurses Association, at the September Business Assembly meeting.

Sherwood C. Young, executive secretary of the Society, was congratulated on being graduated from the Institute for Advanced Management Studies at the Michigan State University.

Elected at the December meeting as officers of the society for 1969 were Irvin G. Shaffer, M.D., president; David N. Farber, M.D., president-elect; and Charles N. Wang, M.D., treasurer. The resignation of Paul W. Stolz, M.D. as editor of the *Medical Record* was accepted with deep regret. His fine editorials and handling of scientific and other copy has made the *Medical Record* one of the best small county society publications in the country.

The Annual Banquet, an old fashioned fun night with libations, good fellowship, quiet conversation and an excellent dinner, was held on January 15 at the Berkshire Country Club.

Arthur H. Keeney, M.D., ophthalmologist in chief, Wills Eye Hospital, and professor and chairman of the department of ophthalmology, Temple University Medical School, presented a most interesting program at the February meeting on "Medical Guides for Physicians in Determining Fitness to Drive a Motor Vehicle".

The Medical Society has been providing real medical leadership in the Health Planning Committee for the Reading Model Cities Program, being represented by R. William Alexander, M.D.; John P. Scully, M.D.; Sherwood C. Young; Bernard D. Eaton, M.D. and Gordon A. Kagen, M.D.

Air pollution was the subject of a meeting in April to which the general public and the officials of all the municipalities in Berks County were invited. Representatives from the National Air Pollution Control Administration and a panel composed of Society members and representatives of the Pennsylvania Department of Health conducted the meeting.

BUCKS COUNTY

In honor of the Woman's Auxiliary of the society, a joint meeting was held on September 11 at the Holiday Inn, Bristol, with Representative John Renninger, a member of the Pennsylvania Legislature, speaking on state and regional medical programs.

Mr. John Rineman, assistant executive director of the Pennsylvania Medical Society, was the speaker at a "Gripe Session" of the society held at Conti's Inn, Doylestown, in October.

Gomer T. Williams, M.D. was presented with the Pennsylvania Medical Society's Fifty Year Service Award at the December meeting by Elmer Mears, M.D., president of the County Society. John S. Detwiler, Quakertown, Pa. was appointed as executive secretary of the society, effective January, 1969.

At the Annual Meeting in January, Richard E. Fox, M.D. was inducted as president for 1969 by Elmer Mears, M.D., retiring president.

A joint meeting of the Bucks County Bar Association and the society was held on March 12 at the Doylestown Country Club. The speaker for the evening was Robert L. Sadoff, M.D., of Jenkintown whose subject was "Court Martial at Da Nang."

During 1968, the Bucks County Medical Society Foundation made the following grants: The Bucks County Chapter of the American Cancer Society, $500; the Bucks County Homemakers Service, $500; and the Bucks County Association for the Blind, $1300.

During the year, the Scholarship Fund was renamed the Jacques Babbin Memorial Scholarship Fund in memory of a beloved member and editor of the *Bulletin* who died in 1968.

CHESTER COUNTY

The fall season was opened with a presentation of the film "The Contraceptive Patient" at the September meeting. Arthur Byler, M.D., was presented with a Merit Award by the Brandywine District, Region Three, Boy Scouts of America for his work as chairman of the Boy Scout Committee of the Society.

The Annual Meeting of the society was held January 15 at the Red Rose Inn near Oxford. The following officers were elected: President Russell G. Doyle, M.D.; President-Elect Michael B. Dooley, M.D.; Vice-President H. L. Tindall, M.D.; Treasurer William J. Barry, M.D.; and Secretary Donald E. Harrop, M.D. Past president's pins were presented to all of the living past presidents. A gift of appreciation was presented to Erwin R. Zeller,

M.D., retiring treasurer, for his untiring services as treasurer over several years. The County Society Group Benjamin Rush Award was presented to the Junior Century Club of Coatesville and the Individual Benjamin Rush Award was presented to Michael Eller, a fourteen-year-old Oxford High School boy.

"Reading Problems" was the interesting subject discussed by Dr. Milton Brutten, director of the Vanguard Schools at the March meeting.

A joint meeting on medicine and religion was held at the Coatesville Veterans' Hospital in April with Leo Bartemeier, M.D., medical director of Seton Psychiatric Institute, Baltimore, Md., speaking on "The Changing Relationship between the Medical Man and the Clergyman".

The June meeting was held at the Valley Forge General Hospital, Phoenixville, Pa., with the staff of the hospital providing the program. The meeting was preceded by golf and swimming and followed by a social hour and dinner.

DELAWARE COUNTY

A referendum for the establishment of a county health department was voted on at the November elections. Sponsored by and actively supported by the Society and numerous health and welfare agencies in the County, the proposal was defeated by a vote of 89,938 against the proposal and 66,559 in favor of it. J. Albright Jones, M.D., and Robert F. Plotkin, M.D., co-chairman of the Society's Commission on Public Health and Preventive Medicine, and William Y. Rial, M.D., serving as president of Citizens for Better Health, Inc., played very active parts in the campaign.

Mr. Bernard Greenberg, director of insurance, pensions and unemployment benefits for the United Steel Workers of America, A.F.L.-C.I.O., was the speaker at the November meeting. His interesting subject was "Can America Provide High Quality Medical Care for All?"

The Annual Dinner Meeting of the Society was held at the Alpine Inn, Springfield. J. Vernon Ellson, M.D., was inducted as president for 1969 by Arthur H. Silvers, M.D., retiring president. A traditional silver gift was presented to Dr. Silvers by Hunter S. Neal, M.D., secretary of the Society, who also presented the Pennsylvania Medical Society's Fifty Year Service Award to Joseph DiMedio, M.D. Gerald D. Dorman, M.D., president-elect of the American Medical Association, was an honored guest at the meeting.

Starting in January 1969, the society will reduce the number of meetings of the society from ten to five per year.

A Legislative Dinner was held on March 27 at the Media Inn with James W. Dunn, M.D., and Lawrence Mellon, M.D., co-chairmen of the committee presenting an interesting agenda for discussion.

At the March meeting an interesting program was presented by Merrill B. Hayes, M.D., chairman of the Commission on Inter-Professional Relations, on the subject "Yes or No—Delaware County Medical Society's Participation in Medico-Legal Panels for Screening Medical Malpractice Cases". 'Pro' and 'con' opinions were given by members of the Delaware County Bar Association.

LEHIGH COUNTY

At the September meeting, eight interns from the Allentown Hospital addressed the members on the subject "A New Physician Looks at Organized Medicine".

The Greater Lehigh County Area Scholarship Fund reported that $6,500 in grants had been awarded to twenty-two applicants during 1968-69 for scholarships in paramedical fields.

On October 30, the Society hosted local educators during the 17th Annual Business-Education Day, with the cooperation of several hospitals.

During the implementation of the Eleventh Annual Diabetes Detection Program 12,884 individuals were screened. This resulted in the discovery of 155 abnormal blood sugars, of which, after further investigation, 30 new cases of diabetes were diagnosed.

The Annual Banquet was held on January 18 at the Holiday Inn (West) of Allentown. Fourteen new members elected during the year were introduced. The Pennsylvania Medical Society's Fifty Year Service Awards were presented to Roland W. Bachman, M.D., and Carl J. Newhart, M.D. E. John Stahler, M.D., was inducted into office as president for 1969. A President's Plaque was presented to Robert J. Beitel, Jr., M.D., in recognition of his fine services during the year.

A space spectacular, including "The Physician's Role in Manned Space Flight," was presented at the February meeting by Lt. Col. Kenneth N. Beers of the medical research and operations directorate of the N.A.S.A. Manned Space Craft Center, Houston, Texas.

The Nineteenth Annual Benjamin Rush Award luncheon was held at the Lehigh Valley Club on March 5. Leo C. Eddinger, M.D., was toastmaster and spoke on the origin of the Benjamin Rush Awards. The Individual Award was given to Mr. Robert C. Fredericks for his leadership and untiring efforts in establishing "Haven House." The Group Award was given to the Service to the Blind Committee of the Sisterhood of Congregational Keneseth Israel for exceptional work as readers, braillers, and recorders to help blind individuals keep abreast of the times.

A joint meeting with the Lehigh County Bar Association was held at the Lehigh Valley Club on May 13 with Alfred M. Sadler, Jr., M.D., and Blair L. Sadler, L.L.B., the speakers.

MONTGOMERY COUNTY

The county society held ten meetings during the year. The Annual Medical-Legal Dinner meeting was held at the Plymouth Country Club, Norristown, Pa. James E. Nixon, M.D., team physician for the Philadelphia Eagles spoke on the problems of orthopedic surgery with respect to athletes.

At the November meeting, McNeil Laboratories, Inc., was named recipient of the 1968 Montgomery County Medical Society Occupational Health Award and the Pennsylvania Medical Society Occupational Health Award, the latter being presented by Mark R. Leadbetter, M.D., chairman of the PMS Commission on Occupational Health.

The annual dinner dance of the society, the "Fall Frolic", sponsored by the Woman's Auxiliary, was held on November 16 at the Plymouth Country Club.

The Annual Meeting of the society was held on January 8 at the Medical Society Building. The following officers for 1969, duly nominated at the November meeting, were elected and inducted into office: President Frank S. Tornetta, M.D.; President-Elect Charles S. Ami-

don, M.D.; First Vice-President Edgar W. Kline, M.D.; Recording Secretary Ulysses E. Watson, M.D.; and Treasurer Joseph L. Hunsberger, M.D. The American Medical Association's Humanitarian Service Award was presented by M. Louise Gloeckner, M.D., to Pio J. Pezzi, M.D., for his services in connection with the Volunteer Physicians for Vietnam Program of the American Medical Association.

A joint meeting with the Woman's Auxiliary was held on February 5 with the ladies preparing an enjoyable luncheon for the members of the society. Frank J. Tornetta, M.D., president of the society, presented gavels to nineteen past presidents who were present at the meeting, the oldest in point of service being Remo Fabri, M.D., who was president in 1929.

The June dinner meeting was held at the Valley Forge Hotel with Edward R. Annis, M.D., past-president of the American Medical Association, and a member of the AMA board of trustees as speaker. During the meeting, Dr. Annis was elected an honorary member of the Montgomery County Medical Society and presented with an appropriate scroll.

THIRD COUNCILOR DISTRICT

Ralph K. Shields, M.D.

In behalf of the membership in the Third Councilor District, and personally, I would like to pay tribute to our former district councilor, our colleague and friend, the late Joseph A. Walsh, M.D., whose unexpired term I am completing. Dr. Walsh served our district well. We shall miss his dedication to service and his friendliness.

Three of the county medical societies have been, to date, visited officially and visits will be made to the remaining two county medical societies.

A business meeting of the Lackawanna County Medical Society was attended in the fall of 1968. The Annual Inaugural Dinner Dance, which was a very fine affair, was also attended on February 15, 1969.

A very interesting meeting of the Carbon County Medical Society, which included members of the clergy, was attended May 8, 1969. The panel discussion was on "Medicine and Religion" and included speakers from the Geisinger Medical Center in Danville, Pa., focusing particularly on organ transplants.

Most of the meetings of my own Northampton County Medical Society have been attended, including the very fine annual inaugural dinner in January, 1969. A very nice part of this affair was the installation of the incoming president of our very active Woman's Auxiliary.

Perhaps the most significant meeting in our district was held at the Pocono Manor Inn on April 12, 1969. In attendance were the officers from every component county medical society in the District. Also in attendance were State President George E. Farrar, Jr., M.D., and members of the staff of the Pennsylvania Medical Society. We had a roundtable discussion in the afternoon at which time various aspects of organized medicine were discussed. Included in the discussion were: the structure of organized medicine, malpractice insurance problems, legal problems, and Blue Shield matters. A social hour and dinner followed the meeting.

It was agreed that the meeting provided an opportunity to become acquainted and to discuss mutual problems. All in attendance felt that it was worthwhile and the group voted to have a similar affair on September 27, 1969, at the Pocono Manor Inn. Wives will be invited to attend the next affair.

I believe that Councilor District meetings should be encouraged. Such get-togethers can be meaningful from several standpoints. First, and perhaps of prime importance, is the need to point out the important role organized medicine must play in shaping the future of health care and the practice of medicine. Second, such meetings provide an opportunity to exchange ideas with colleagues, officers, and staff members of the Pennsylvania Medical Society. Third, an opportunity is provided for county society representatives to be brought up to date on legislation, Blue Shield matters, malpractice insurance and other matters by staff personnel between the annual sessions of the House of Delegates. These would constitute, in effect, "regional meetings of the Pennsylvania Medical Society" which would make possible a better informed and more involved membership, and this we urgently need.

FOURTH COUNCILOR DISTRICT

George A. Rowland, M.D.

The Fourth Councilor District has had a relatively quiet year even though external forces are making inroads in the area which will greatly affect the lives of both doctors and patients. Growth of population and ease of access have already resulted in a loss of isolation for this area which had previously been remote and very rural.

Medically speaking, much attention has been directed toward the care of acute coronary artery disease and most of the hospitals are setting up or preparing for coronary care units. A boost to this activity has resulted from grants obtained by the Susquehanna Valley Regional Medical Program which will help pay for these units in a number of hospitals in the District. A number of physicians have been active in this program.

Another development that has had an impact on health in the District has been the Rural Health Demonstration Project, a federally-financed program which has involved some of the physicians, health professionals, and consumers in the project area, which differs from the Fourth District only in that it includes Union County instead of Schuylkill. A house-to-house survey was made of the counties in the rural health project under the aegis of the Susquehanna Valley Regional Medical Program. This was also carried out in Schuylkill County. Although the results are not completely tabulated, it seems likely that much information will be forthcoming on the health status and needs of the people in this area. The funding of the demonstration project will shortly come to an end, but plans are underway to carry the organization of this program into comprehensive health planning jointly with several additional neighboring counties.

There have been no new malpractice suits brought to the attention of this Councilor. This area remains relatively free from litigation and malpractice insurance is still readily available to physicians. There have been no problems presented to the Councilor District Review Committee. Efforts to initiate joint activities among the societies have met with some interest, but little progress has taken place this year.

COLUMBIA COUNTY

Luncheon meetings continue to be held by the Columbia County Medical Society with good scientific speakers and attendance that approaches 50 per cent of the active members. There is feeling among some of the officers that very little would be gained by holding meetings jointly with other societies.

Columbia County has received the mixed blessing of being included in both the Susquehanna Valley Regional Medical Program and the Greater Delaware Valley Regional Medical Program. A few of the members of the Society have been somewhat active in both programs and the Rural Health Demonstration Project. Both the Bloomsburg and Berwick hospitals applied for help in establishing coronary care units through the Greater Delaware Valley Program, but in neither case did they meet with success. The Berwick Hospital has already established its own unit and Bloomsburg is preparing to do so.

MONTOUR COUNTY

The Montour County Medical Society is largely synonymous with the Medical Staff of the Geisinger Medical Center and thereby maintains high quality scientific programs with excellent attendance. There is perhaps not quite as much interest in socioeconomic problems, although several members of this Society have been quite active in both the Susquehanna Valley Regional Medical Program and comprehensive health planning. Under the Regional Medical Program a grant was made to the Geisinger Hospital for a nurses training program for coronary care units. This will certainly be a step forward for all of the institutions in this section. The Montour County Medical Society has also shown interest in holding at least some of its meetings jointly with neighboring county societies.

NORTHUMBERLAND COUNTY

The Northumberland County Medical Society maintains a high degree of activity with 45 active members, 8 senior active members, 7 associates, and 1 affiliate member. Scientific meetings were held in September, October, November, March, April, and May. In addition, the Society hosted doctors from all over the area at the annual Rea and Derick party which was addressed by George E. Farrar, Jr., M.D., president, Pennsylvania Medical Society.

The Society was active in the educational field presenting a course on current medical and surgical concepts, alternately at Sunbury and Shamokin, in cooperation with the Council on Education and Science. In addition, a one day program on cancer of the rectum was sponsored in conjunction with the American Cancer Society.

Members of this Society have been most active in the Susquehanna Valley Regional Medical Program. Several of these doctors have been members of the Northeastern Area Committee of that organization and were instrumental in gaining federal funds for coronary care units at both the Shamokin and Sunbury hospitals. Active interest also was evidenced in the Rural Health Demonstration Project. The activities of this Society are an occasion for pride.

SCHUYLKILL COUNTY

No answer to communication with this county has been received, but the Councilor did attend a regular meeting where a good speaker was heard by a fair turnout of the members. This Society holds meetings in the Spring and the Fall plus an annual President's Party in December. There is a Bulletin which is sent only to members of the Society.

Some members of the Schuylkill County Medical Society have been active in the Regional Medical Program and assistance was obtained for several coronary care units in the hospitals of that county.

SUMMARY

The county societies of this District continue usual activities principally centered around regular scientific meetings. The physicians are concerned with changes in modern medicine in general, and particularly in this area. Activity in the Regional Medical Programs is increasing and beginning to bear fruit. It is hoped that more cooperative ventures may be initiated among the county medical societies in the Fourth District in the ensuing year.

FIFTH COUNCILOR DISTRICT

David S. Masland, M.D.

The 1968-1969 year has been one of varied activities by the county medical societies of our district. I will review these activities as reported to me by the component societies.

ADAMS COUNTY

This county points out two problems which are not unique to the counties of this district. The first is that this society has had some difficulty in selecting delegates to the House because of the split between the Scientific Session and the Annual Session of the House of Delegates. Previously, members were able to attend both meetings and found the experience more rewarding than they do now following the split of the two sessions. I think this may continue to be somewhat of a problem, particularly with the smaller societies.

The Adams County Medical Society, as has Cumberland, also points out the difficulty which rural areas are having in obtaining physicians. The average age of the physicians in these counties is increasing, and there are increasing numbers of small communities which are not served directly by any physicians.

CUMBERLAND COUNTY

The Cumberland County Medical Society has continued to be active throughout the past year. This county continued to be active in the legislative sphere. Individual doctors endorsed and heartily supported George A. Goodling, congressman from the Nineteenth Congressional District. We are happy to report that Congressman Goodling was successful in his bid for reelection.

This county, like a number of others over the years, has increased its Medical Aid Fund which is under the management of the Educational and Scientific Trust of the Pennsylvania Medical Society. The fund has grown to $15,255. In February, 1969, in addition to the other loans already granted, Mr. Rodney Fritchley, a junior medical student at the University of Pennsylvania, was presented a loan of $1,450 to support a perceptorship in Asia this coming summer.

Cumberland County had difficulty in making a determination whether to continue sponsoring mass immunization programs. Finally, on March 16, a measles program was carried out with approximately 1,900 immunizations given. The society has questioned whether or not mass immunization programs should be continued because of the legal liability to which members are exposed and would like to request guidance from the Pennsylvania Medical Society regarding whether the State Society would advise the continuation of mass immunization programs sponsored by county medical societies.

In May, 1969, the Cumberland County Society had its second annual premedical student dinner at Dickinson College. This was attended by over sixty people. The colleges represented were Dickinson, Messiah, Shippensburg, Gettysburg, and the Harrisburg Area Community College. M. Prince Brigham, M.D., dean of admissions at Temple University School of Medicine, was the speaker. We feel this dinner has been especially helpful in bringing together the premedical students in the surrounding colleges with the physicians of the area. Robert Gasull, M.D., the president-elect for the coming year, plans an extremely active program for the Cumberland County Medical Society.

DAUPHIN COUNTY

During the past year, between meetings of the PMS House of Delegates, the Dauphin County Medical Society revised its Constitution and Bylaws. As a result of this action, this Society now has four councils, as follows: (1) Providing Quality Medical Care, (2) Financing Medical Care, (3) Interprofessional and Public Relations and (4) Members' Services. The revised Constitution and Bylaws have been approved by the Pennsylvania Medical Society.

In cooperation with the Fifth District Councilor, this Society sponsored a Fifth Councilor District Meeting on comprehensive health planning in May, 1968. The Dauphin County Medical Society stands ready to participate with the Pennsylvania Medical Society, the Pennsylvania Department of Health and other interested parties in the vital area of planning as specified in P.L. 89-749.

The society and the Harrisburg Academy of Medicine sponsored a joint meeting in December, 1968, at which representatives of the Susquehanna Valley Regional Medical Program (SVRMP) presented a progress report on its activities in implementing P.L. 89-239. At SVRMP'S request, the society nominated three members to serve on the Subcommittees on Heart, Cancer and Stroke of the Executive Committee of the Southern Area of SVRMP.

Members of the society assisted the Cumberland County Medical Society and the Pennsylvania Department of Health in a Measles Immunization Program conducted by these organizations in early 1969 for eligible Cumberland County children. The Dauphin County Medical Society conducted the 26th annual DPT immunization Program for first grade pupils of Harrisburg public and parochial schools.

The society is an active supporter of the Student American Medical Association and recently contributed $200 to the local SAMA Chapter at the Pennsylvania State University College of Medicine for its use in participating at SAMA's National Convention in Chicago this year.

Presently, the society is working with local health agencies, hospitals and interested citizens in the establishment of a neighborhood health clinic in the Hamilton section of Harrisburg and also plans to conduct a migrant workers health project this year in upper Dauphin County in cooperation with the Pennsylvania Department of Health. The society will also conduct physical examinations this year on children planning to attend the summer camp of the Police Athletic League of Harrisburg.

This society was privileged to honor Mr. Lester H. Perry, executive director of the Pennsylvania Medical Society at its May meeting by presenting him with an engraved plaque in recognition and appreciation of his thirty-five years of dedicated and loyal service to the medical profession of Pennsylvania. At the meeting, Mr. Perry discussed "The Perennial Challenges of Medicine". The Dauphin County Medical Society congratulated Mr. Perry on his many accomplishments for organized medicine, and extends best wishes to him for a well-earned, happy retirement.

Within the next year, the Dauphin County Medical Society will strive to develop a county-wide emergency medical and disaster program, conduct a survey on fees, strengthen the M.D.-D.O. relationship, grant assistance to deceased members' families, determine long-range goals for the society and establish a Dauphin County Foundation for Health Care.

FRANKLIN COUNTY

The Franklin County Medical Society is again to be congratulated on having an active and well-run society with active participation by a large percentage of its members. This society meets monthly, has speakers from its own society and the surrounding areas, and, as stated, has excellent attendance. These speakers have covered a wide range of topics, from scientific medicine to economic problems.

During the past year, there were two members of this society who passed away: George Poe, M.D., and Louis Ostroff, M.D. The society gained two new members: John Ashby, M.D., and George Baker, M.D. Alexander Stewart, M.D., was given a plaque honoring him for 50 years in the practice of medicine. A plaque from the State Society was given to Elmira Sheatz on May 2 to honor her on her one-hundredth birthday. It has been my privilege to visit this county society each year during my term as Trustee. I believe there have been five, fifty-year plaques awarded during this period. I might

suggest we all move to Franklin County; this must be the physician's Shangri-La.

Early in the year, the Franklin County Medical Society carried out a very successful measles mass immunization program in Franklin and Fulton Counties. John Manges, M.D., the very able secretary of the society, continues to serve for another year.

LANCASTER COUNTY

The Lancaster County Medical Society had ten meetings over the last year. Dr. Robert Skinner, III, was elected president. This society also revised its Bylaws in order to conform with the Model Bylaws of the Pennsylvania Medical Society. It is attempting to establish better rapport with the legal profession by the appointment of a liaison committee. It has also sponsored prizes for the Science Fair. During the year, the society awarded the Benjamin Rush Award to Mr. John Gibson for his service with the Heart Association of Lancaster County.

At the May meeting of the Lancaster County Medical Society, the Dental Society and the Bar Association were invited to hear Lt. General L. W. Walt, assistant commandant of the United States Marine Corps. This society is the envy of a number of other societies in that it was able this year to employ an assistant to the executive secretary because of the increased responsibilities.

LEBANON COUNTY

The most noteworthy activity of the Lebanon County Medical Society in the past year has been its sponsorship of three one-day seminars in continuing education conducted by the Jefferson Medical College and the Pennsylvania State University.

A variety of programs was presented during the regular meetings. Of special note was a well-attended joint meeting with the Lebanon County Bar Association.

The Lebanon County Medical Society is presently considering the establishment of a financial aid fund for local medical students. The need for young physicians has become an increasing one in this locality, and it is expected that positive action on this matter will be taken in the near future.

PERRY COUNTY

This county also emphasizes the need for young physicians. O. K. Stephenson, M.D., secretary, points out that the physician population is aging and that no new medical doctor has come into the county for nine years. He predicts that with the inevitability of death and retirement, there will be a crisis soon unless steps are taken to correct this situation.

The Perry County Medical Society has enthusiastically endorsed the programs conceived by the State Society's Committee on General Practice as a possible means of getting new doctors and improving the quality of medical care at the present time. In the belief that young physicians may be attracted by good facilities the Perry County Health Center has been incorporated as a nonprofit organization. This will consist of a medical wing with as complete a diagnostic and therapeutic armamentarium as the society can provide. There is no attempt to make it a hospital, but it will provide a doctor's needs and give patients a facility that has not been hitherto available to them. To meet another local need and to provide more income and also to qualify for 90 per cent FHS financing, the Perry County Medical Society plans to build an attached one hundred-bed nursing home. This will include space for mental health, visiting nurses, and a prenatal clinic. This facility also hopes to have a satellite relationship to the various hospitals so that a pathologist will check on the lab machinery, visiting specialists can come in when there is sufficient accumulation of tough cases, etc. There are plans to train local people in such things as X-ray and laboratory technician work. There is no shortage of nurses.

YORK COUNTY

York County's Secretary, H. Malcolm Read, M.D., the Fifth District's (if not the State's) secretary with the longest tenure, reports that the York County Medical Society is, despite falling attendance at the business meetings, in a healthy condition. Its members are honored to be a part of the Graduate Education Program of the York Hospital, under the direction of their fellow member, Robert L. Evans, M.D. An expansion program for the York Hospital, "Project 80," is actively supported by members of the York County Medical Society.

The society has held business and socio-economic meetings alternately every other month and, though the attendance has not been high, the content of these meetings has been good. The interns and residents of the York Hospital are regularly sponsored for these events, and this proves to be a successful venture in obtaining new members for the Society.

The Committee on Medicine and Religion, inaugurated originally in York County, has established a good reputation. Four sessions were held in March, and attended by many members.

The York County Medical Society has over 225 members, and many applications for membership pending. There are currently seven members in the service. Contact is maintained with these members while away through the monthly publication, *The Bulletin.*

Ninety per cent of the total membership contributes to the Scholarship Fund and under the guidance of A. C. Crovatto, M.D., chairman, financial aid has been provided to several medical students.

The Emergency Call System in York is supported by all members of the Society, and is operated efficiently. Two special meetings were held this year featuring social evenings with dentists and lawyers of the surrounding community. The York County Medical Society conducted a survey among its members regarding human relations and the acceptance of public assistance patients, with a special committee following up.

The York County Medical Society was fortunate in having George E. Farrar, Jr., M.D., PMS president, attend the Annual Banquet in February, 1969, to show slides and movies of his adventures on a raft trip down the Colorado River through Arizona and Colorado.

In conclusion, as can be seen from the above, the county medical societies of the Fifth District have been active throughout the last year. I would like to compliment all the societies on the excellent reporting of their activities.

SIXTH COUNCILOR DISTRICT

H. Thompson Dale, M.D.

It has been a pleasure to represent the Sixth Councilor District at various meetings this past year. I will try to list some of the rewarding experiences I have had.

It was my privilege to attend the first of the Physicians and Nurses Seminars to be held in Pennsylvania, at the Altoona Hospital in December, 1968, and it was very enlightening. I hope these meetings held throughout the state will improve cooperation between our professions.

In February, 1969, we had our Sixth Councilor District meeting at the Nittany Lion Inn, State College, Pa., with senior pre-medical students of Penn State University and Juniata College. Eighty-five college students and forty-five physicians attended this interesting meeting. Our very fine Pennsylvania Medical Society president, George E. Farrar, Jr., M.D., gave an interesting talk on "Your Stomach as Your Dinner Sees It" and illustrated the talk with two very interesting movies. Mr. Thomas McCaghren, editor of PENNSYLVANIA MEDICINE covered this meeting and took several photographs which he used in the article he had on this event in the April issue of PENNSYLVANIA MEDICINE.

I was pleased to receive copies of the lists of the officers and committees of our five county societies.

From time to time I have discussed the need of an executive secretary for our Sixth Councilor District, and I hope the time will soon be here when we can have a full time executive secretary.

BLAIR COUNTY

The Physicians and Nurses Seminar meeting was a success because of Joseph Stowell, M.D., the nurses, hospital administrators and D. George Bloom, M.D., of Johnstown. Richard Magee, M.D., is doing an excellent job as chairman of the Pennsylvania Medical Society Council on Education and Science. Dr. Magee is also doing a fine job on the Appalachia Highlands Area Committee of the Susquehanna Valley Regional Medical Program.

In January, 1969, Mrs. Dale and I were entertained at the annual banquet of this large, active society.

CENTRE COUNTY

John Deardorff, M.D., conducted an excellent experimental vaccination program for German measles with the cooperation of Smith, Kline and French (2013 children and adults cooperated).

In June, 1969, the Physicians, Druggists and Dentists Picnic was held at Mountain Acres Camp and an excellent time was had by all.

This society plans to present a resolution to the House of Delegates this year encouraging ambulance drivers to be trained in first aid and emergency medical treatment.

The Centre County Medical Society has nine scientific meetings a year which are preceded by a business meeting and dinner at a restaurant, country club or hotel in Centre County (about 30 to 35 per cent of the members usually attend the meetings).

On June 5, 1969, ground breaking ceremonies were held in the State College area for the new Mountain View Hospital branch of the Centre County Hospital.

CLEARFIELD COUNTY

This small active society had a very busy year that was highlighted by a bus trip of eighteen of the twenty-five members and wives to the Councilor District meeting at the Nittany Lion Inn, State College, Pa. The County Auxiliary held its meeting and had dinner at the Inn, while the Councilor District meeting was held. Arrangements were made to have enough physicians remain at home to cover the hospital and various communities.

HUNTINGDON COUNTY

This County, which adjoins Centre County, seems separated by the "high mountains" so that little is known by me of the activities of the Society. I was disappointed that only Dickinson Lipphard, M.D., and the ever-faithful William B. West, M.D., attended the Councilor District meeting in State College in February. Juniata College senior pre-medical students were well-represented and the advisor from Huntingdon was also present.

MIFFLIN-JUNIATA COUNTIES

This society was disappointed that its controversial resolution on Title XIX failed to be accepted by the House of Delegates at the September, 1968, meeting. However, I am pleased that the resolution at least did cause quite a bit of discussion.

Mrs. Dale and I were entertained at the annual banquet and dinner-dance of this active Society in January, 1969. At this meeting an interesting booklet was given each member containing the list of officers, past presidents, society committees and the program and dates for each meeting of the ensuing year. Other pertinent information is also presented in the booklet.

I am pleased to represent this District of approximately 300 members and always welcome calls from anyone about problems that may arise.

SEVENTH COUNCILOR DISTRICT

Robert S. Sanford, M.D.

During the past year, the Seventh Councilor District has had no major problems arising and it has been a pleasure for this Councilor to serve the seven counties of the District during this period. The six county medical societies represented have been cooperative throughout the year and the general response of the membership to activities at the county and state levels has been good.

Because of the uniformity of the activities throughout the District, the individual county societies are not being reported upon separately. The only exception is in the case of the Potter County Medical Society. In this Society, the major activities centered around the new Cole Memorial

Hospital, Coudersport, and its medical staff. In this instanee, county society activities and hospital aetivities are coterminous. The major problems for the Potter County Medieal Soeiety are the needs to adequately staff the hospital with qualified physieians and to make the general publie aware of the advantages of the beautiful, modern hospital, the facilities of whieh are adequate to meet the medieal needs of the Potter County area for many years.

In my contact with the county activities throughout the District, I have found unanimous agreement on the need for decentralized, continuing medieal education. The interest in decentralized, continued medical edueation which is now being provided through the Counеil on Education and Science of the Pennsylvania Medieal Society has rapidly exeeeded that for the single-meeting scientifie sessions previously provided. The county medieal soeieties in the District are now more intereсted in having speeialty knowledge brought to them at the local level. Greater local interest is generalized in these courses and the specialty knowledge can be adjusted to loeal needs. Each component society in the District has been sponsoring such educational aetivities on an increasing basis and some joint county edueational programs are also being provided.

This Councilor has been requested by several component county soeieties to urge the Board of Trustees of the Pennsylvania Medical Society to discontinue the annual scientific session and to provide more specialized educational programs at the county soeiety level or even at the hospital staff levels. The excellent Officers' Conference of 1969 has illustrated numerous techniques of bringing continuing education to the eounty or hospital level. We are requesting that these teehniques be utilized on a major seale in the near future to provide educational programs at the local level.

The developing regional medical programs are still plaguing the Seventh Councilor District with respect to distribution of the various programs to the different counties of the Distriet. This Counеilor sees no solution to this problem at the present time, but is attempting to keep in contact with the various government programs to see what is best suited for the various counties, thereby attempting to do as much as possible for the eounties involved.

In summary, this Counеilor has been very gratified with aetivities of the component soeieties of the Seventh Councilor District during the past year. The interest of all component societies at the present time is directed toward the request that the Society develop further continuing education programs for presentation strietly at the county or loeal level. In addition, there is a continuing need among the counties in the Distriet to achieve carefully planned affiliation with health planning programs to the best advantage of the societies involved.

EIGHTH COUNCILOR DISTRICT

James A. Biggins, M.D.

The following is a summary of the activities of some of the county medical societies eomprising the Eighth Councilor District.

CRAWFORD COUNTY

The Woman's Auxiliary was reorganized and now has a joint monthly dinner meeting with the society. This seems to be helpful in stimulating attendance. There is now a liaison eommittee between the staffs of the two hospitals in Meadville. Initial steps have been taken to resolve some differences, such as duplication of serviccs, inequities in admission practices, and the representation of each staff in the society. Some specialty groups are holding combined meetings.

The society lost through death, on the same day, two busy practitioners, Ned D. Mervine, M.D., and Daniel D. Maloney, M.D. This led to creation of a physicians' recruitment eommittee in an effort to attract new physieians to our area.

Representatives of the Soeiety have had several meetings with the Erie, Buffalo, and Pittsburgh groups regarding the comprehensive health planning and regional medical programs, and unfortunately this society has been as confused as the rest of the medical profession about these new laws and their implementation.

Members of the society attended a ten-week series of seminars eonducted by the Pennsylvania Medical Society. These were well reeeived and attended by a large number of doetors from our eounty. Excellent speakers and subjects of practical interest were combined with gracious hospitality by Spencer Hospital. Each session was preceded by a gourmet luncheon sponsored jointly by City and Spencer Hospitals, which greatly aided attendance and enthusiasm.

ERIE COUNTY

The principal activities of a most suceessful year were as follows:

- Sabin Scholarship Fund awarded $3,500 to twenty-one applicants.
- Participation in the Boy Scout summer examination program.
- Awarding of plaques in honor of two centenarians.
- Two new committees formed and functioning: Medicine-Religion and Insuranee Review.
- Successful candidacy of Carl B. Lechner, M.D., for the office of president-eleet of the Pennsylvania Medical Society.
- Conducting of community disaster drill with John S. Chaffee, M.D., serving as chairman of the medical teams.
- Pennsylvania Medieal Society "Voice of Medicine" plaque presented to Russell B. Roth, M.D., for his many years of statewide publie speaking on numerous health projects.
- Certain members have been instrumental in beginning early study of the feasibility of a medical school in northwestern Pennsylvania.
- For the first time in many years the society exceeded its United Fund goal.
- In the comprehensive health planning program, George J. D'Angelo, M.D., chairman, made significant

progress in the Erie area. Plans to ensure early receipt of funds from the federal government for the purpose of study, organization, and the determination of programs necessary in Erie County are under way.

- Liaison has been established with the County Bar Association. The Medical-Legal Committee is working with the bar association to establish ground rules for handling problems.
- Participation in the regional medical program with headquarters in Buffalo, New York, including several telephone conferences.
- An active bowling league won several trophies in out-of-state matches.
- Three successful golf tournaments were held.
- Three membership meetings were held, as well as monthly Executive Committee meetings, with the exception of July and August.

The membership of the society is as follows: active members, 207 (regular, 199; temporary, 5; senior active, 1; resident, 2); affiliate members, 1; associate members, 26 (regular, 25; temporary, 1). Seven new members joined the Society: Rogelio A. Cruz, M.D.; John M. Edington, M.D.; William C. Hendricks, Jr., M.D.; William D. Loose, M.D.; Tomas A. Mariano, Jr., M.D.; John P. Mraz, M.D.; and William T. Smyth, M.D. Four members passed away during the year: Usher H. Myers, M.D.; William V. Sarine, M.D.; Felix S. Shubert, M.D.; and Vere K. Worster, M.D. Two members transferred: Alan E. Shipley, M.D., and Tomas A. Mariano, Jr., M.D. Two members are in the military service: Juan F. Delgado, M.D., and Douglas C. Rist, M.D.

MERCER COUNTY

With an initial grant of $5,262, the Mercer County Medical Society established within the Educational and Scientific Trust of the Pennsylvania Medical Society the Mercer County Medical Educational Fund. This fund will be used to provide loans or grants to residents of Mercer County to assist in paying tuition at approved schools where they are enrolled in courses in either the medical or paramedical field.

At the March meeting of the Society, Charles L. Hudson, M.D., from the American Medical Association, was present and addressed the meeting, to which hospital boards of trustees of the county were invited. In May, the local nominees for the Benjamin Rush Award were recognized. An executive meeting of the Society was canceled in June because of a local curfew.

The Sharon Steel Corporation was awarded the Pennsylvania Medical Society Industrial Health Award at a luncheon with the representatives of the corporation and a group of society representatives. There was a successful meeting with members of the clergy at a regular society meeting which was devoted to medicine and religion. In June there was a well attended meeting with the dental society and their wives for a social evening. Regular meetings of the Executive Committee are held preliminary to each scheduled monthly meeting.

There are ninety-six members at present. There were two deaths during the past year: William A. Beatty, M.D., and Charles H. Moses, M.D., both of Sharon.

Comment has been requested concerning participation in the regional medical program and the comprehensive health program. The Mercer County Medical Society has been represented at all meetings in this county on these programs. These programs are still formless, seeking purpose (and federal money, of course) and so far lacking direction in Mercer County (which is the most populous county in Western Pennsylvania between Erie County and Allegheny County). The meetings held in this connection thus far have been so lacking of any purposeful agenda except for vague conceptional guidelines and the known desires of planners as to be an affront to the intelligence of a busy practicing physician and unfair imposition on his time when asked to attend. This is in no way intended to say that this society is unaware of the potential impact of these programs. Up to now, they have been frustrating and the forecast calls for more of the same. It would seem that prior to the time these programs become significant, they will have succeeded in stifling whatever minimal physician interest it has been possible to stimulate.

CONCLUDING REMARKS:

Unfortunately, no reports had been received from the McKean and Warren County Medical Societies at the time this report was prepared.

An Eighth Councilor District meeting was held in Sharon on June 25. Present were: Robert O. Byers, M.D., and David J. Keck, M.D., from Erie County, and M. Wilson Snyder, M.D., John F. Coyne, M.D., and Allen H. Holt, M.D., from Mercer County. Carl B. Lechner, M.D., and Russell B. Roth, M.D., sent their regrets. Calls were received from William T. Holland, M.D., M. Elizabeth Cleland, M.D., and Ross E. Bryan, M.D., explaining their inability to attend. Officers and delegates from each county society in the Eighth District had been invited. The meeting was successful, but disappointing, because of the small number present. The interest and enthusiasm in informal activities seemed to make up for the small number. Discussions were led by John F. Rineman and Robert H. Craig, Jr., of the Pennsylvania Medical Society staff, and Jerry L. Rothenberger of the Pennsylvania Medical Political Action Committee.

I would now like to indulge in some philosophical musings as a "lame duck" since I am resigning as Trustee and Councilor for this District effective at the Annual Session. Some of the inactivity in this District from December through June may be a reflection of the inability of the Councilor, due to illness, to be active except for attendance at the May meeting of the Board of Trustees. It has been a stimulating and educational experience to serve as a member of the Board of Trustees of the Pennsylvania Medical Society since 1963. But it has also been a frustrating experience as Councilor because of inability or reluctance to attend meetings of each of the component societies because of the pressures of practice—but not because of disinterest.

As a member of the Benjamin Rush and the Finance Committees of the Board of Trustees and, of course, as a member of the board itself, there was a considerable period of orientation before I felt I was being useful. I have been very impressed by the character and sincerity of the other members who serve on the board. The efficiency and constant availability of the PMS staff has been a real pleasure to enjoy.

Lester Perry and his successor John Rineman have been "just what the doctor ordered." The retirement of Richard

Sloan, I note with regret. David Small has been very helpful at all times. I am impressed with the effectiveness with which Alex Stewart manages the Education and Scientific Trust.

I feel that the members of the Finance Committee with Park Horton as Chairman, and the able assistance of Bill Limberger, Chairman of the Board, have done well in managing the affairs of the Society delegated to them. It is gratifying to know that the Officers' Conference will be continued because I feel it serves a useful purpose in encouraging new officers in the component societies to become more active in their own societies and the State Society.

The activities of the PMS Delegation to the AMA deserve high praise.

The new PMS Headquarters Building has more than justified the dreams of the men who originally envisioned such a building.

I feel that Syd Sinclair has served his present masters and organized medicine well.

I am sure that the future of the Pennsylvania Medical Society will be guided by equally ardent and sincere men and women and I heartily recommend them to our House of Delegates.

NINTH COUNCILOR DISTRICT

Cyrus B. Slease, M.D.

The six counties comprising the Ninth Councilor District have held regular scheduled meetings during the past year. These have consisted of business meetings, social meetings, and scientific meetings; sometimes combined and sometimes separate. At the time this report is written, I have visited three of the counties in the District.

The county society auxiliaries have actively pursued their worthwhile activities and have been a source of continuing support.

Several district physicians are active in the Regional Medical Programs and the Comprehensive Health Planning Program, serving on key committees. Ninth District physicians have been represented and participated in practically all regional meetings. This is as it should be. However, I urge still greater participation since the more active district members become, the greater possibility there will be of achieving more practical and beneficial activity through the area advisory groups and in comprehensive health planning in general.

I am proud of the physicians of the Ninth District for their integrity and their willingness to think first of the patient. So far this year all disputed claims have been settled by discussion and the services of the Councilor District Review Committee have not been required.

It appears to me that the only way to make up for the current shortage of practitioners is to make various medical services available to more people through clinics or medical centers.

I wish to thank the component societies and individual physician members of the Ninth District for their continued cooperation.

TENTH COUNCILOR DISTRICT

William J. Kelly, M.D.

BEAVER COUNTY

This County's present total membership numbers 159. Numerous physicians in the county were active in speaking on many medical and surgical subjects especially heart disease, cancer, venereal disease and organ transplants. The scientific meeting for September, 1968 was combined with the Woman's Auxiliary and organized by the Medicine and Religion Committee. The speakers—a rabbi, priest and a protestant minister—presented various topics relative to present day problems.

In October, 1968, the Medical Society and Beaver County Heart Association sponsored a public heart forum with two internationally known cardiologists, Drs. Friedberg and Lillehei, as the main speakers.

In November, 1968, a dinner dance was held jointly with the local dentists organization and a delightful time was had by all.

In December, 1968, the Annual Indoctrination Luncheon was held with the Society welcoming new members into the ranks of organized medicine. During the Christmas holidays, the Annual Dinner for the medical students residing in Beaver County was held. This is becoming more popular each year. It is the earnest hope of this society that many of these students will return to this county to start their practice in medicine.

In April, 1968, many of the members of this active society met with their legislators for dinner and informal discussions regarding pending medical legislation.

The New Program Committee of this society has brought in some very renowned and interesting speakers for their various scientific programs, which has increased attendance considerably. This committee is to be congratulated for an outstanding effort in behalf of this county society.

The annual golf outing this year was conglomerated with the lawyers and dentists and was very successful. Eugene Berkman, M.D., was presented with two Vietnam service Awards at this meeting.

The fourth annual Health-O-Rama was held June 12 through June 15. This was sponsored jointly by the Medical Society, the United Fund and the Commissioners of Beaver County. Through this effort in the past three years, excluding this year, more than 81,000 health tests have been provided to residents of this area. This county continues to pursue a very active interest in meetings, both local and state-wide, especially in Pittsburgh, relative to comprehensive and regional medical planning.

In conclusion, may I say that as your Councilor, I was very pleased with the performance of your very active county this past year and considered myself more than privileged to be invited and to be able to attend many of these functions.

LAWRENCE COUNTY

The Lawrence County Medical Society had twelve executive committee meetings this past year. In addition, nine business meetings were held in which excellent speakers from both Pittsburgh and Cleveland participated. The Annual Christmas Party for wives and members was well attended in December.

Although one year ago it was decided this society needed an executive secretary, to date this person has not been obtained. As a result, the secretary still continues to go through large volumes of correspondence at a heavy cost to his time and the county's aetivities. They are, however, still trying diligently to procure one.

Good news to this society has been the recent settling of the hospital strike.

Another very serious concern for this society has been its physician population. Statistics as provided by this society reveal that one half of the seventy-five physicians in Lawrence County are over the age of sixty. This is causing growing concern in the county medical society and a very active effort is being made to procure younger physicians for the area.

The Lawrence County Medical Society is aware of and realizes the importance also of comprehensive health planning and public health service policies and has encouraged its members to participate actively in these areas.

It is the recommendation of this Councilor that the Pennsylvania Medical Society explore the means of providing at least a part time executive secretary for this society, so that this soeiety ean get back into the main stream of organized medical activity.

WESTMORELAND COUNTY

This society's membership totals 245 in the various categories with only 215 being active members.

Ten excellent society meetings were held throughout the year, climaxed by Annual May Clinic and a combined meeting with the Indiana County Medical Society and Auxiliary at the Torrance State Hospital. The members had dinner with the Auxiliary on two occasions followed by interesting speakers. The auxiliary entertained the society with a dinner-dance at the Greensburg County Club. The April meeting was held in conjunction with the Heart Association. The Westmoreland County Medical Society Scholarship Fund renewed four scholarships and awarded two new ones for 1968-69.

This society has maintained a very sincere and active interest in Comprehensive Health Planning such as demonstrated in the June issue of its *Bulletin* which is almost exclusively devoted to this subject in order to inform the membership of the scope and content of this health planning idea.

This Councilor has been very pleased with the attitudes and activities of this county society during the past year.

ALLEGHENY COUNTY

In 1969, there has been a vigorous attempt on the part of this Society to be a leader in medical affairs in this community.

Poverty Committee

This society continues to stimulate medical service programs for persons of low income. Several innovative projects are underway, especially in the Hill District of Pittsburgh which is in a Model Cities area.

Comprehensive Health Planning

Allegheny County met with representatives of ten county medical societies in Western Pennsylvania this year to consider an application to establish a 314(b) agency for comprehensive health planning. Six county medical societies have reviewed and endorsed the application in principle and others are reviewing the material. The application has been approved in Harrisburg and forwarded to the regional office of the Public Health Service in New York for consideration.

In summary, ACMS representatives were of the opinion that these activities need strong physician participation in order to provide adequate professional guidance. The society intends to pursue these activities vigorously in the future to provide support for programs which are of concern to the medical profession in the interest of improving the quality of medical care. In connection with these activities, this county society has worked closely with physicians and staff members of the Pennsylvania Medical Society.

Allegheny County Council on Emergency Medical & Health Services

The Council has completed its second year and a substantial amount of progress can be reported. Although funds from the State and Federal government are antieipated in support of these aetivities, we are awaiting final action at the time of preparing this report. More than twenty organizations in Allegheny County have contributed the time of their representatives on a part-time basis and many worthwhile results have been achieved.

The Allegheny County Medical Society has played a leading role in the Council. Its committees are pursuing the following activities: (1) promotion of adequate records and statistics regarding emergency care; (2) setting up county-wide plans for twenty four-hour coverage in all fields of medicine; (3) providing active participation by physicians responsible for emergency care in thirty hospitals; (4) providing instruction for the training of paramedical personnel, including ambulance drivers, attendants, and nurses; (5) correlating disaster plans for Allegheny County; and (6) developing new transportation and communication systems.

Regional Medical Program

The Regional Medical Program includes thirty-one counties in Western Pennsylvania and Allegheny County with Allegheny County as a major resource in support of these activities. The society has cooperated in the implementation of this program and is interested in aiding the Regional Medical Program in becoming more meaningful to practicing physicians.

Allegheny County Medical Society Foundation

The Foundation contributed $700 to the Buhl Planetarium for the Sex Education Program for Children.

It contributed $500 to Allegheny County Council on Emergency Medical Health Services.

Several other projects are presently under consideration by the Foundation, including the possible provision of

grants for disadvantaged medical students at the University of Pittsburgh.

Headquarters Building

Additional property has been purchased including a building which may be renovated as a temporary office until a headquarters building is constructed.

Three physicians who served in the Volunteer Physicians for Vietnam Program were honored at a business meeting of the Society.

The Board of Directors has approved specialty listings of physicians in the yellow pages of the Pittsburgh telephone directories. It has also approved the invitation of representative members of the Board of the other county medical societies in the Tenth Councilor District to attend the ACMS Board Meetings in order to bring about closer liaison among the societies in the District.

A member of the society was suspended from membership in the Society by the Disciplinary Committee for contempt of the Judicial Board.

Additions to office personnel were also made. One new secretary was employed by the Society and, in addition, a new employee was retained to serve as Public Relations Consultant and Managing Editor of the *Bulletin*.

Other Society activities which have been continued in 1969 include training of police and firemen in first aid, participation in School Science Fair, speaking engagements on medical and related topics, TV appearances and programs sponsored by the membership, co-sponsorship of Health-O-Rama, provision of personnel to man the hospital at the County Fair, participation in comprehensive health planning, liaison with the Hospital Council of Western Pennsylvania and the Hospital Planning Association, Hospital Utilization Project, Blue Cross Review Committee, Medical Care Coordinating Committee, Grievance Committee review and disposition of complaints, child health care, Utilization Review Committee, sponsorship of the Annual Meeting of the Allegheny County Medical Society and the Allegheny County Bar Association, and sponsorship of Careers of Exposition at the Civic Arena with the cooperation of students at the University of Pittsburgh.

In conclusion, this Councilor can only say to the Allegheny County Medical Society, "Thanks, for a job extremely well done."

Concluding Remarks

In summary, may I again report to the House of Delegates that I have continued to supply each county society in this district with a summary of the actions taken at each meeting of the Pennsylvania Medical Society Board of Trustees. In addition, I would like to point out that I have had excellent cooperation from the secretaries of each of the component societies. I feel each of the societies in this District has continued to maintain the stature and image of medicine at a very high level and should be congratulated for doing so. It has been a privilege for me to work with them.

ELEVENTH COUNCILOR DISTRICT

D. George Bloom, M.D.

The Eleventh Councilor District has had an active year which began with a Councilor District meeting last September, held in conjunction with the 1968 Annual Session. This meeting showed a marked improvement over the 1967 meeting. All the component societies in the District were represented and participated except Bedford County. The meeting convened at 3:00 p.m. and adjourned at 5:00 p.m., and substantial interest was shown in the proceedings. Subjects discussed included: The suggestion that component societies hold a regular meeting in Harrisburg as guests of the State Society; the regional medical program; the Benjamin Rush Award Program; Blue Shield plans to offer a prevailing fee program on an individual basis; dissatisfaction resulting from the inclusion of chiropractors in Pennsycare; and each resolution to be considered by the House of Delegates.

Matthew Marshall, Jr., M.D., chairman of the Blue Cross Regional Steering Committee of Western Pennsylvania, requested that each of the involved Councilor Districts designate a member and alternate to serve on the Regional Steering Committee. After a mail and telephone canvass of the District, the following physicians were appointed:

Member—John H. Hall, M.D., Washington County

Alternate—Gerald I. Schor, M.D., Washington County

The first meeting of the Blue Cross Regional Steering Committee was held in May, 1969.

In April letters were sent to each component society in the District advising of the request of the Council on Governmental Relations that county societies hold legislator-physician dinners. It was pointed out that these functions give county society members an opportunity to meet informally with their legislators and discuss problems and also acquaint legislators with their physician constituents. In April, I also wrote to county societies asking that they provide me with an annual report relative to their participation in the regional medical programs and the comprehensive health planning program.

During the year, I have attended meetings of the Board of Trustees, a hearing of the Joint State Government Commission, a meeting of the Pennsylvania League of Nurses in State College at which I spoke on paramedical licensure, a physician/nurse seminar held in Altoona, a meeting with representatives of SVRMP and WPRMP in Bedford, as well as several other meetings.

Below follows a summary of the activities reported by several of the component county societies.

BEDFORD COUNTY

James K. Gordon, M.D., secretary, and John E. Hartle, M.D., president, advise that the Bedford County Medical Society has no special programs to report on for the past year. However, a building expansion is planned for the present hospital and practically all of the society members are presently devoting considerable time to this program. The customary business and scientific meetings were held as usual.

CAMBRIA COUNTY

The past year saw the adoption of a revised Constitution and Bylaws by the Cambria County Medical Society.

This document was brought up to date to conform with the many changes in the Pennsylvania Medical Society Constitution, especially in membership classifications. Other changes resulted in delegation of more of the routine business of the society to the Board of Directors, streamlining of the committee structure, and the charging of the Committee on Education with the additional responsibility of planning the scientific sessions at the regular Society meetings.

The most important public health undertaking of the society was a mass immunization program of school and preschool children against measles. This campaign was conducted in cooperation with the Pennsylvania Department of Health. The county society also had the cooperation of the school nurses, the school boards, the county superintendent, and many other volunteers. It was a highly successful effort.

A joint committee of members of the medical society and the Cambria County Bar Association has drawn up the "Cambria County Medico-Legal Interprofessional Code." This code was approved and adopted in May, 1969.

The county society maintained an active role in regional planning, having delegates attend all planning sessions. Society members are occupying key positions in all phases of regional planning, assuring competent medical representation in this activity of growing importance. Projects currently under way in which members are participating include the establishment of a regional faculty to promote postgraduate education, various educational programs for nurses, a training program for home health aides, and a program to improve care for hypertension.

Society membership has remained constant with new members balancing out the attrition caused by death and retirement.

FAYETTE COUNTY

The following were some of the more important activities of the Fayette County Medical Society during the 1968-69 year:

- Celebration of the society's 100th Anniversary with a dinner-dance and much publicity on May 17, 1969.
- Publication of a history of the Fayette County Medical Society from 1922 to the present (in a prior history the period from 1765 to 1922 had been covered). The history is entitled "Physicians in Transition" and took approximately two years of hard work to complete.
- A joint meeting of the society and the Fayette County Bar Association.
- A joint meeting with pharmacists.
- Cosponsorship with the Washington County Medical Society and the Southwestern Pennsylvania Heart Association of two programs: "Arteriosclerosis—Prevention and Control" (April) and "Stroke Rehabilitation" (May).

In addition, the society carried on its normal business and scientific meetings. Fortunately the Grievance Committee was not called upon this year.

WASHINGTON COUNTY

The following were some of the important activities of the Washington County Medical Society during the 1968-69 year:

- Participation in a scientific meeting on cardiac surgery under the auspices of the Washington Hospital Staff Education Committee in October, 1968.
- A joint dinner-dance with the Washington County Bar Association in October, 1968.
- The sending of letters to each hospital in Washington County requesting that a physician be appointed to serve as a member of the governing board of the hospital. This was in accord with a resolution adopted by the AMA House of Delegates in 1966 and a resolution adopted by the PMS House of Delegates in 1967.
- Cooperation with the Washington County Jaycees to donate drugs for project "Operation Concern."
- Cooperation with the University of Pittsburgh Graduate School of Public Health in answering cancer survey questionnaires circulated to physicians in Washington County.
- Endorsement of a program to be sponsored by the Woman's Auxiliary to start a Future Physicians' Club in Washington County.
- Endorsement in March, 1969, of a request by the Washington County Tuberculosis Association for a new technique of "tine testing."
- Approval in March, 1969, of amblyopia screenings for pre-school children requested by Washington County Association for the Blind.
- Participation in April, 1969, in a scientific program sponsored by the Washington-Greene County Heart Association.
- Purchase of the film "Parent to Child About Sex" by the county society, which has been shown to a number of organizations.
- The society's Benjamin Rush Award nominee, Mr. George Stewart of the Observer Publishing Company, was honored at the annual June dinner.

One of our members, Malcolm E. Ruben, M.D., is serving on the Western Pennsylvania Comprehensive Health Committee. Ernest L. Abernathy, M.D., delivered innumerable speeches on smoking, under the auspices of the American Cancer Society. He also participated in a high school program on drug addiction using the film "Escape to Nowhere." The society gained five new members. Two were lost through transfer to other counties in the state. One member moved out of the state.

CONCLUDING REMARKS

Unfortunately, at the time this was written, I had not yet received reports from the Greene and Somerset County Medical Societies. However, I have been advised that the Greene County Medical Society and the Somerset County Medical Society are both participating in the comprehensive health planning activities in their areas.

During the course of the 1968-69, year the Committee on Objectives conducted a survey concerning the possibility of councilor district reorganization. The Committee suggested that this matter be considered from the point of view of the need to improve communications between the State Society, component county medical societies, and individual members in order to increase the effectiveness of organized medicine. I would like to take this opportunity to comment on this subject.

The Eleventh Councilor District is geographically rather

peculiar. Greene County is 94 miles from the Southern tip of Cambria County and 130 miles from the Northern tip of Cambria County. All the counties in the District are situated along the Maryland border except Washington and Cambria Counties.

Cambria County has no social activities, educational programs or patient referrals in common with Washington, Greene or Fayette Counties. Cambria County is itself divided and the physicians in the north rarely attend county society meetings. About nineteen physicians from Somerset County are members of the Cambria County Medical Society. I believe the physicians in the northern section of Cambria County associate primarily with the Blair and Indiana County Medical Societies.

Washington County is situated on the Ohio border and is west of Westmoreland and Allegheny Counties. I understand the Washington County Medical Society is divided in a fashion similar to Cambria.

Bedford County is involved primarily with the Susquehanna Valley Regional Medical Program and eventually the flow of patients from this area will be directed primarily to Altoona and Harrisburg.

It appears to me that a study of the educational programs, patient flow, political interests, and social interests of this Councilor District (and perhaps others) should be undertaken so that a new area which takes these factors into account could be constituted as a councilor district.

I believe that the councilor districts should cross county lines, rather than be divided by them. This would require a great deal of research in order to determine the geographic flow of patients and the desires of members in order to determine with which area they should associate to best serve both patients and physicians.

Without further study, I am unable to make any recommendations for reorganization of the Eleventh Councilor District. However as Trustee and Councilor I am somewhat dissatisfied. I have tried to make appointments to visit the component societies. It has been very difficult to make mutually convenient arrangements. I have also had the feeling that the county societies in this District are not very interested in the activities at the District level.

I wish to thank the officers and members of all the county medical societies in the District for their participation in the preparation of this report and for making this year a successful one for the Eleventh Councilor District.

TWELFTH COUNCILOR DISTRICT

Park M. Horton, M.D.

The Luzerne County Medical Society has 328 members (this total includes the Hazleton Branch of County Society). The headquarters building of the Society is at 130 South Franklin St., Wilkes-Barre, and houses its library and the Professional Services Bureau. Mrs. Leona O. Franey is the excutive secretary. The Board of Directors meets the first Wednesday and the general membership meets the third Wednesday of each month. In October, a very successful Medicine and Religion meeting was sponsored by the society together with King's College, Wilkes-Barre Law and Library Association, and the Wyoming Valley Clergy Ecumenical Dialogue Group, to commemorate International Human Rights Year. The society held its annual banquet January 19, 1969, at Fox Hill Country Club. At this meeting, the Benjamin Rush Awards were presented to Mrs. William Jones of Kingston, Pennsylvania, and Saint Stanislaus Institute of Sheatown. Also at this meeting, Russell L. Stevens, M.D. completed his year as president of the Society and installed William R. A. Boben, M.D., as president for 1969. The Society also held joint meetings with the Luzerne County Dental Society and the Luzerne County Pharmaceutical Association.

The Hazleton Branch Society, with Stanley Yamulla, M.D., as president, holds regular scientific and business meetings and is represented at the parent society board meetings by John J. Coyle, M.D.

Several members are active in the Area-Wide Health and Hospital Planning Program. Representatives of the Model Cities Program presented plans for a model clinic site in the Heights section of the city of Wilkes-Barre at both a Board of Directors meeting and a general membership meeting.

The Luzerne County Medical Society Bulletin, with Edward R. Janjigian, M.D. as editor, is published monthly except July and August. It is an excellent publication and should be read with pride by every member of the society.

The Women's Auxiliary of the Luzerne County Medical Society, with Mrs. Thomas Gazowski as president, is very active and a great asset to the society; their programs and projects are to be commended.

The Bradford County Medical Society has sixty-six active members, four associate members and three resident members. William C. Beck, M.D., is president and James McQuillen, M.D., is secretary. This society holds monthly meetings with outstanding scientific programs. On December 11, 1968, the Society held a joint meeting with the Bradford County Bar Association, the Tioga County (New York) Medical Society, and the Tioga County (New York) Bar Association. Dr. Arthur B. King, neurosurgeon, Guthrie Clinic-Robert Packer Hospital, spoke on "Some Philosophical Problems Jointly Involving Medicine and Law."

Several members of this society participate in the activities of the Susquehanna Valley Regional Medical Program. Dr. Beck is a member of the Regional Advisory Group and Dr. McQuillen is chairman of the Council on Stroke.

Also several members of the society have been active in the New York-Pennsylvania Regional Planning Group. Dr. Beck and Mr. Jones (Administrator of the Robert Packer Hospital) are members of the Board of Directors of this council.

The Woman's Auxiliary of the Bradford County Medical Society is very active, holds regular meetings concurrently with the county society and has interesting and informative programs.

The Susquehanna County Medical Society has fourteen members. The society holds regular meetings each month

except July and August. R. C. Davis, M.D., succeeded James Miller, M.D., as president at the monthly meeting for January, 1969. During the past year the scientific programs have been presented by members of the society with the meetings being held alternately at the Montrose General Hospital and the Barnes Community Hospital. This society has also conducted monthly sessions of instruction for ambulance crews. All members of the society participated as instructors and the courses were well attended. All ambulance groups in Susquehanna County were represented.

Members of the Susquehanna County Medical Society belong to the Board of Directors of the Health and Hospital Planning Council of Northeastern Pennsylvania and the New York-Pennsylvania Regional Planning Group and attend the meetings of each of these groups. This County Society is also represented on the Board Committee of the Susquehanna Valley Regional Medical Program.

The Wyoming County Medical Society has nine active members and holds regular meetings every other month. At its annual meeting William R. Host, M.D., succeeded John S. Rinehimer, Jr., M.D., as president. This Society has a well-organized emergency medical service, which works to the benefit of the entire county. Members of this Society are active in the organization of the Health and Hospital Planning Council of Northeastern Pennsylvania. Some members have also participated in the activities of the Greater Delaware Valley Regional Medical Program. Charles J. H. Kraft, M.D., secretary of the society, is a member of the Council on Governmental Relations of the Pennsylvania Medical Society and is completing his tenth year on the Council on Rural Health of the AMA.

There are no organized auxiliaries of Susquehanna and Wyoming County Medical Societies, but several of the wives are members-at-large of the State Auxiliary.

The Twelfth Councilor District Physicians' Advisory Committee to Blue Cross of Northeastern Pennsylvania was organized September 20, 1968, William Pearlman, M.D., of Wilkes-Barre as chairman.

On September 26, 1968, a Councilor District Meeting was held in the Pittsburgh Hilton Hotel. All county societies in the district were represented and activities of the forthcoming meeting of the House of Delegates as they affected the Twelfth District were discussed.

SUMMARY REPORTS OF STANDING COMMITTEES

AID TO EDUCATION

The loan and scholarship programs of the Educational Fund, together with the other student aid programs of the Educational and Scientific Trust, assisted 237 students with scholarships and loans of $172,039 during the 1968-69 school year. Of these students, 166 were in medical school with the help of loan and scholarship assistance amounting to $132,899.

Sixty-six medical students graduating in 1969 received $118,582 while in medical school.

As of June 15, the applications received for financial assistance to attend medical schools during 1969-70 exceeds the total number of applications received last year. This is due to the schools receiving less money from the Federal Government to provide loans under the Health Professions Loan Program.

The Committee on Aid to Education recommends that $8.00 be allocated from the 1970 annual assessment for the Educational and Scientific Trust to support this worthwhile loan and scholarship program.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

No formal meetings of the Advisory Committee were held during the year. However, several items of business were transacted by mail.

The Committee reviewed and approved the program for the Twenty-third Annual Mid-Year Conference held April 16-17, 1969, at the Hershey Motor Lodge, Hershey, Pa.

The priority projects recommended by the Program Development Committee to the Board of Directors were approved by the Advisory Committee. The priority projects for 1969-70 will be American Medical Association Education and Research Foundation (AMA-ERF), Children and Youth, Health Careers, Legislation, and Membership.

The Program Extension Committees adopted by the Board of Directors were approved by this Committee. The following Program Extension Committees will be utilized during the ensuing year: Children and Youth, Community Health, Conference, Convention, Health Careers, Home-Centered Health Care, International Health Activities, Legislation, Mental Health, Necrology, and Safety-Disaster Preparedness.

Donations contributed by Auxiliary members to the American Medical Association Education and Research

Foundation, Educational Fund of the Educational and Scientific Trust, and Medical Benevolence Fund from May 1, 1968, to April 30, 1969, totaled $17,471.58.

The Health Careers Chairman reported that county auxiliaries presented twenty-nine loans and fifty-three scholarships. The county loans amounted to $9,950 and the scholarships totaled $14,375. Tripartitely, the county loans and scholarships were divided with $1,450 for medicine, $20,200 for nursing education, and $2,675 for other careers. In addition, many counties sponsored health career days, tours, and workshops.

STUDY RELATIONS BETWEEN MEDICINE AND OSTEOPATHY

The Committee reports several interesting developments during the year which shows medicine extending its hand to osteopathy to a much greater degree than ever before. The Committee reports activities at the AMA level which extend not only to membership possibilities but training possibilities for osteopaths.

The Committee also reports on the activity of the State Board of Medical Education and Licensure which offers medical training to graduates of osteopathic colleges.

MEDICAL BENEVOLENCE

During 1968, the Committee on Medical Benevolence provided $39,610 in assistance to twenty-six family groups with monthly grants ranging from $50 to $300.

Three physicians' widows were added to the list of beneficiaries and two physicians received temporary aid for their families while the physician members were ill.

Contributions received from county components of the Woman's Auxiliary and other individuals amounted to $8,521 for the year.

It is the Committee's recommendation that the allocation from the annual assessment again be set at $1.00 per active member.

OBJECTIVES

The Committee met four times during the past year. The various subjects of its deliberations are discussed below.

In its report to the 1968 House of Delegates, the Committee indicated it was on the verge of concluding its study of the topic "Delivery of Medical Services." A summary of the Committee's study and conclusions was published in the January issue of PENNSYLVANIA MEDICINE for the benefit of the membership. In the conclusion of this article, the Committee identified several trends likely to develop significantly in the next ten to fifteen years. During the course of the year, these trends were brought to the attention of the Board of Trustees. The Board in turn referred them to the appropriate administrative councils for further study and development so that they would be taken into consideration in the formulation of Society policy in the future.

In 1968, the Committee reported that it had recommended to the Board of Trustees that the desirability of reorganizing councilor districts be explored with the objective of improving communications between the state society, component county medical societies, and individual members and increasing the effectiveness of organized medicine. The Board of Trustees approved this recommendation and designated the Committee on Objectives as the unit to study this matter.

In order to meet this request, the Committee conducted a survey of county medical societies and district councilors. It was suggested in this survey that consideration be given to the concept of "district societies," based on natural medical service areas, which would be sufficiently large to support an administrative staff. The respondents were asked to keep the following factors in mind in filling out the questionnaires:

1. The ease with which physicians in the area under consideration can get together (transportation and communications).
2. Common professional interests of physicians within the area.
3. The physician population in the area (representation should be based to some degree on this).
4. The need for improved communications with the state medical society.

Forty-one out of sixty county medical societies and six out of twelve district councilors responded to the survey. The preponderance of these responses indicated satisfaction with the status quo. Two of the six responding Councilors indicated a desire for change, and seven of the forty-one responding county medical societies indicated an interest in realignment. In addition, several more county societies evidenced a willingness to consider and discuss any changes that might be proposed.

One county medical society indicated an interest in sharing an executive secretary with other societies. It is also worth noting that, in general, the county societies that appear to be most satisfied with present arrangements are those which have executive secretaries—such as Allegheny, Dauphin, Lancaster and those in the Second Councilor District.

It is the conclusion of the Committee on Objectives, as a result of this survey, that the root of the communi-

cations problem does not lie in the Society's organizational structure. Rather, we believe it is a function of the limitations of time and interest on the part of individual physicians, which in some cases is enhanced by geography. The barriers of geography are gradually being removed, but we do not know to what degree the barriers of time and interest on the part of the individual physician can be overcome. These circumstances lead us to reaffirm our belief that county medical societies, jointly or individually, should continue to be strongly encouraged to employ administrative staffs whenever possible.

The results of this survey notwithstanding, the Committee believes that it may become desirable at some time in the future to organize district medical societies in accordance with the patterns in which medical services are delivered. This may be essential in maintaining effective physician participation in organized medicine. Such patterns could probably be identified best according to focal points such as medical care centers and/or population centers. *We believe that it would be useful to have a model plan developed which outlines these patterns. The Committee recommends that the appropriate administrative unit be designated to develop such a plan and report back to the House of Delegates in 1970 on this matter.*

Following the 1968 Annual Session, the Board of Trustees referred Dr. Farrar's remarks regarding the possibility of periodic relicensure for physicians to the Committee on Objectives since this is a matter related in large part to future goals. In his comments, Dr. Farrar had recommended that the possibility of periodic relicensure be explored and that consideration be given to the requirement of educational credits for continuance of membership. After considering this matter, the Committee made the following comments in its report to the Board of Trustees:

"The Committee on Objectives believes that the possibility of periodic relicensure for physicians carries within it inherent pitfalls and problems which have not been explored sufficiently at this time. We have been informed, not to our surprise, that the program of relicensure currently being started in Oregon is encountering many complications.

"The basic difficulty, we believe, is that taking away a person's ability to work and earn a living, the inevitable result of failure to renew a license, is a rather drastic step, and will possibly create as many problems as it solves. For this reason we believe that the Society's efforts in this area should be focused on a more effective voluntary continuing education program in the immediate future. If it becomes necessary to take stronger action at a later time as a result of outside pressures we favor a relicensure system based on educational credits rather than 'challenge examinations.'

"The Committee has also been informed that the State Board of Medical Education and Licensure is conducting a survey to ascertain whether physicians have undertaken continuing education work during the last two years. We recommend that the Council on Education and Science investigate the results of this survey in its study of relicensure."

The above remarks were subsequently referred to the Council on Education and Science by the Board of Trustees. It is our understanding that the Council is studying this matter in depth at the present time.

The Committee is devoting several meetings this year to a review of Society programs and objectives. In order to go about this systematically, the Committee corresponded with the Society's major administrative units—the four councils—as well as with a number of committees. The first object of this correspondence was to ascertain whether any duplication or overlapping existed among the activities of the various councils, committees, and commissions. We are pleased to report that we found no significant instances of duplication. In a few areas where responsibilities are divided between two administrative units, activities are coordinated at the staff level and through the Board of Trustees. In carrying out this study, the Committee also examined the budgets of the administrative councils with an eye toward determining from a budgetary point of view whether the Society's priorities are in the right place.

The second facet of this review involves consideration of the Society's goals and its long-range plans to achieve these goals. In this connection, the Committee has asked each of the four administrative councils for an outline of its goals and long-range plans. The Committee plans to review these as regards consistency and to utilize them in drawing up a comprehensive statement of Society objectives for consideration by the Board of Trustees and House of Delegates. We anticipate that we will report to the House of Delegates in this regard in 1970.

CONSTITUTION AND BYLAWS

The Committee met in May to consider a referral from the Board of Trustees, as well as to discuss several other matters of business, as outlined below.

At the Clinical Convention in December, 1968, the House of Delegates of the American Medical Association adopted the following statement of objectives with respect to osteopathy:

"The American Medical Association seeks to:

1. Assure the provision of the best possible health care to the American people;
2. Make available to students and graduates in osteopathy education of the same high standards as prevail in undergraduate, graduate and continuing educational programs in medicine;
3. Provide avenues whereby qualified osteopaths may be assimilated into the mainstream of medicine."

The AMA House of Delegates also approved a nine-point plan for attaining these objectives. The fourth of these points reads as follows:

"The American Medical Association suggests that each county and state medical society may accept qualified osteopaths as active members and thereby provide for their membership in the American Medical Association."

The Committee on Constitution and Bylaws gave serious consideration to the many problems involved in making osteopaths eligible for active membership. The difficulties

notwithstanding, your Committee is in accord with the objectives of the American Medical Association which are expressed above. We have therefore prepared amendments to the Constitution and Bylaws which would permit osteopaths to be members of the Pennsylvania Medical Society. These amendments are published in the "Official Call to the 1969 Annual Session." In submitting these amendments for consideration, we wish to make it clear that providing eligibility for membership to osteopaths is no panacea for achieving the goals adopted by the American Medical Association. However, we firmly believe this is a step in the right direction.

It was brought to the Committee's attention there is a redundancy in Section 5, "Affiliate Member," of Article IV of the Constitution which has caused some minor confusion in determining who is eligible for this class of membership. In order to correct this, the Committee recommends that the word "educational" be deleted from the subsection "b" of Section 5. This is essentially a technical correction and does not involve a change in the interpretation of this section of the Constitution.

The Board of Trustees referred to the Committee a letter from R. William Alexander, M.D., chairman, Council on Public Service, concerning the language in the Bylaw provisions regulating reinstatement of a member who is delinquent in paying his annual assessment. This language in Chapter I, Section 5 of the Bylaws indicates that ". . . any person whose membership has been terminated for failure to pay a delinquent assessment shall be automatically reinstated to membership upon payment of the delinquent assessment in full before December 31 of the assessment year . . ." Dr. Alexander indicated that he felt members should have an incentive to pay their dues punctually, and that this would he facilitated if reinstatement were not "automatic."

Since county medical societies are the only portal to the Pennsylvania Medical Society, they have the responsibility of ensuring that members are reputable and thus entitled to membership. Consequently, in considering new applications for membership, county medical societies take appropriate measures to screen all applicants. It is the Committee's belief that county medical societies should be entitled to exercise similar discretion if they wish when reinstating members whose membership has been terminated because of delinquency in paying the annual assessment. Consequently, we are recommending that the portion of Chapter I, Section 5 quoted above be amended to read that ". . . any person whose membership has been terminated for failure to pay a delinquent assessment shall be reinstated to membership upon payment of the delinquent assessment in full before December 31 of the assessment year and *reinstatement by his component society* . . ."

It was suggested at the Committee's meeting that medical students should be granted a greater measure of opportunity to participate in Society affairs by giving them a voice in the House of Delegates. Committee members felt this would have several advantages. First, it would give concerned medical students a formal means of bringing their proposals and problems to the attention of the medical profession. The Committee believes that, in general, medical students today are more mature and well-informed than they were a generation ago. We think this fact should be acknowledged by extending them greater responsibility.

Secondly, the Society has long sought a means of encouraging young physicians to interest themselves in the affairs of organized medicine. We believe that giving students a voice in the House of Delegates would be an excellent means of stimulating interest in organized medicine and encouraging future participation. The Committee therefore strongly favors such a change.

In our opinion the most effective way to give medical students a voice in the House of Delegates is to allow them to have full-fledged representation. We therefore recommend that the president of each SAMA Chapter in Pennsylvania or an alternate in his place serve as a member of the House of Delegates with the right to vote, serve on reference committees, and the power to introduce resolutions. In making this recommendation, we wish to emphasize that we think the right to vote is essential if the inclusion of SAMA representatives in the House of Delegates is to be meaningful.

Amendments to effect the addition of SAMA Presidents to the House of Delegates have been drafted and are published in the "Official Call to the 1969 Annual Session." We urge their adoption.

Routine business during the year included the publication of a revised edition of the Constitution and Bylaws in which the amendments approved by the 1968 House of Delegates were incorporated and the publication of a revised version of the "Model Bylaws for a Pennsylvania County Medical Society."

DISCIPLINE

The Committee on Discipline held a telephone conference and meeting during the 1968-69 year. The subject of both discussions was a disciplinary problem in which the Committee was asked to provide guidance and assistance by a hospital medical staff. In order to investigate this matter, the Committee spent a full day at the hospital in question. Subsequently, a report containing the Committee's findings and recommendations was rendered to the medical staff. The Committee on Discipline plans to maintain contact with the involved medical staff pending resolution of this problem.

While the Committee has not been extremely active, we believe that in the instances when it has been called upon its functions have been vital, as in the above instance which involves a very serious problem that might otherwise not have been acted upon. In order to ensure that all county medical societies are aware of the Committee's availability for consultation, we have again reminded county medical society secretaries that they may contact the Committee regarding any grievance or disciplinary problems that may be facing them. County society secretaries were also reminded of the availability of the procedural check list for Boards of Censors which may be used to facilitate consideration of individual cases.

The Committee has continued to maintain liaison with the Pennsylvania State Board of Medical Education and Licensure. The Chairman of the State Board serves as an ex-officio member of this Committee, thereby facilitating

this task. Committee members noted with deep regret the passing of Walter R. Seip, M.D., former chairman, last March. Subsequently, we welcomed John F. Hartman, Jr., M.D., present acting chairman of the State Board, to membership on the Committee.

Customarily, the requests the Committee has received for assistance have been few in number. In past reports we have speculated that this must be for one or more of the following three reasons: 1) that there are relatively few complaints in Pennsylvania concerning the conduct of physicians; 2) that county medical society grievance committees have been doing an outstanding job; or 3) that this Committee is not being utilized to its fullest extent. In order to ascertain to what degree the above three possibilities are true, the Committee has determined to initiate an annual survey of county medical societies regarding the number of grievances considered and disciplinary actions taken. This will be patterned after a similar AMA survey that is conducted annually. Current plans call for initiating the survey in January, 1970. The results will be reported to the House of Delegates and possibly be published in PENNSYLVANIA MEDICINE. It is our hope that this activity will yield some useful information. At the same time, we hope that it will serve as a reminder to the membership that self-discipline is one of the hallmarks of an honorable profession and that organized medicine should take an active role in ensuring that its members are ethical and competent.

SUMMARY REPORTS OF SPECIAL COMMITTEES

RELATIONSHIPS WITH ALLIED PROFESSIONS

The Committee on Relationships with Allied Professions reports their activities during the year with representatives of the Pennsylvania Nurses Association and the Pennsylvania League for Nursing and the regional physician/nurse seminars that have been held.

The report also touches on meetings held between the Pennsylvania Funeral Directors Association and proposed meetings with the Pennsylvania Optometric Association.

One of the continuing liaison problems facing the Committee is liaison being conducted by other groups in the Society so that this Committee is not the only body in the Society having liaison with allied professions. The Committee feels, however, that as long as the Board of Trustees keeps the channels separated, no problems of duplication or omission should occur.

MEDICINE AND RELIGION

The chairman of the Pennsylvania State Committee attended the Regional Medicine and Religion Workshop of the AMA in New York City in February, 1969. Again, Pennsylvania contributed, to a significant degree, many ideas that have proved effective in promoting the purposes of the program.

County medical society programming continues to be the vehicle through which clergymen and physicians are brought together with greatest ease. The County Medical Societies of Allegheny and Philadelphia have actively used television in publicizing the medicine and religion movement.

The course in mental health entitled "Counseling the Troubled Person" has been studied and endorsed by Joseph Adlestein, M.D., commissioner of Pennsylvania's Office of Mental Health. It is Dr. Adlestein's recommendation that the directors of the comprehensive mental health centers, created by the Mental Health and Mental Retardation Act of 1966, promote and participate in the development of these courses in the communities served by these centers.

The Board of Trustees has authorized a Medicine and Religion Workshop to be held at the Scientific Session at Host Farm in Lancaster in the fall of 1969. The Board of Trustees has declared March of 1970 as Medicine and Religion Month in this State.

In addition to the promotion of dialogue between actively practicing physicians and clergymen, attention directed to the seminaries and medical schools will eventually be pursued in an effort to abolish the interprofessional gap at the student level in areas of mental health, the home and hospital care of a sick patient, and problems of medical morality.

The most recent visual aid developed by the American Medical Association for the promotion of medicine and religion dialogue is the thirty-minute sound film entitled, "A Storm, A Strife."

GENERAL PRACTICE

The Committee is assisting in and following closely the progress of the Perry Health Center, which is incorporated as a non-profit organization. The corporation will build a medical clinic to accommodate four or more

doctors with treatment facilities that are not now available within the county. To serve another local need, a 100-bed nursing home will be attached to it. The Center can help the hospital's bed utilization and the hospitals can help the Center by specialist consultation when needed. The Health Center will provide emergency medical care on a temporary basis and it will provide, hopefully, the perpetuation of medical care in the Perry County area. This type medical complex can provide space for the Mental Health and Mental Retardation Program of Cumberland-Perry County and a base for ancillary services, such as visiting nurses and social service. The only obstacle to the immediate opening of the Health Center is financing.

Recommendations

1. That the Federal Government be encouraged to provide low interest loans for construction and equipping of modern medical clinics in medically underdeveloped areas, urban and rural.
2. That the Federal Government be encouraged to provide more financial assistance to medical schools for education of students. This would be in addition to, not in lieu of, funds provided for research at medical schools.
3. That the State Medical Society find some place to revive the "Medical Practice Day" or other means of establishing better contact between organized medicine and the medical students.

SUMMARY REPORTS OF ADMINISTRATIVE COUNCILS

PUBLIC SERVICE

In its full report and in this summary, the Council on Public Service gives an account of stewardship that shows steady progress, along with a few frustrations. It is the broad objective of the Council to achieve for the physician ideal circumstances consistent with making the highest quality medical care easily available and desirable to all persons.

More specifically, it is our goal to convey to the public an awareness that the physician's concern goes beyond his circle of patients to a concern for the health and well being of all persons. This is a component of all of our public relations projects. It exists in everything from the health education column to an awards program, from a radio show to a health careers recruitment activity.

The Council also is charged with professional relations and the "ideal circumstances" part of our broad objective obviously includes the involvement of the physician in the affairs of his county, state and national societies because progress toward the objective depends on a united effort as well as individual adherence to the profession's principles. It is a part of all of our professional relations activities.

What the Council has been able to accomplish is based on the existence in the medical profession of more good men and women than there are in any other profession, in any other segment of our population. Without that human resource of goodness, the Council's efforts would be futile. However, the Council fears that that "human resource of goodness" is diminishing at a time when there is a great need for it to increase. The Council endorses wholeheartedly a statement made by A. Reynolds Crane, M.D., of Philadelphia, First District trustee and councilor, who said: "What the medical profession needs is more physicians who love people."

Because of the Council's myriad activities, it has divided its thirteen members into nine different advisory committees with each committee responsible for a specific segment of activities.

In the radio and television area, the use of the five-minute weekly radio show, "Today's Health" continues at a near-record high of seventy-five stations using it regularly and an additional half-dozen stations use a shorter version. This provides 100 per cent coverage of Pennsylvania plus coverage in portions of all adjacent states. The Council's "Instant News" service for radio and some TV stations continues its wide acceptance and is the mechanism for broadcasting brief health and safety education messages and comments keyed to current medical news. We also furnish scripts to a number of county medical societies who then use local physicians to record the announcements with local radio stations. The Council has produced a number of radio documentaries on vital health topics, such as drug abuse, child abuse, traffic safety, air pollution, heart transplants, etc. In television, the Council faces its biggest frustration. It is thwarted by staggering costs in its efforts to produce documentary programs for television and instead has concentrated its efforts in producing "spot" announcements for viewing on public service time. Since the last annual report, topics of these "spots" have included Halloween safety, Christmas safety, poison prevention, bicycle safety, skiing safety, boating safety and pre-school examinations. The Council currently is urging the AMA to undertake documentary TV programming and has offered its assistance in such an effort.

By mid-year, the Council had joined with the Pennsylvania Federation of Women's Clubs in a joint effort to combat drug abuse with the production of a series of TV sound, color film announcements for use in the coming school year. The Federation contributed $10,000 to the project and the Council committed a like amount in staff time, talent and funds.

Key representatives of all news media are contacted by both staff and physicians on a regular basis and in a variety of ways. News releases have been distributed regularly on important topics and have enjoyed excellent use. The Society has expanded its role in the annual meetings of the Pennsylvania Society of Newspaper Editors, the Pennsylvania Newspaper Publishers' Association and the Pennsylvania Women's Press Association. The Society's Donaldson Awards for outstanding reporting has helped

in this regard. Use of the weekly health education column produced by the State Society continues to grow. It is used by about 400 daily and weekly newspapers, industry publications and others. We continue to produce a one-page roundup of state society news for distribution in quantity to county societies without bulletins who then mail it along with meeting notices to their members. The regular Monitor roundup of news is sent to the editors of county society bulletins for inclusion in their publications.

The Service Manual, with detailed information about major activities and programs of the State Society, was revised this year and re-released to key county society officers. Among the variety of printed materials produced by the Council is a booklet outlining the services and functions of the State Society, a booklet for the orientation of new members, leaflets on appropriate health education and socio-economic subjects, health education posters, leaflets on the benefits of State Society membership and others.

The awards programs administered by the Council continue to gather public and professional relations benefits. They include the Benjamin Rush Awards for outstanding voluntary efforts in the health field, the Donaldson Awards for newspaper, radio and TV medical reporting, the Centenarian Awards for persons who achieve the age of 100, the Fifty-Year Awards for State Society members in practice for that length of time and a variety of awards for specific contributions of selected members of the Society.

The State Society Speakers' Bureau has experienced considerable growth in the past year and the physician members of the Bureau participated in a speech training seminar sponsored by the Council and the AMA.

Health career recruitment activities have continued but the formation of additional Future Physicians Clubs, designed by the Council as a public relations program as well as a recruitment effort, has not met Council expectations because many county societies have not participated.

Contact has increased with medical students, interns and residents and a Council-designed course on the socio-economic aspects of medicine is scheduled to begin for interns and residents on a trial basis in two hospitals. Contacts with Student American Medical Association chapters have been increased and student representatives have been attending the meetings of the Council.

The Council has continued its work with a valuable ally, the Pennsylvania Association of Medical Assistants. PAMA membership has increased but some physicians still deny the organization the support it so richly deserves.

The distribution of health education pamphlets has increased in the past year, largely because of AMA price reductions that followed criticisms from the Council. A pamphlet on drug abuse was one of the most widely distributed ones.

The Council continues to provide a one-day orientation session at the State Society headquarters for secretaries of county societies. Only about half of the county society secretaries have participated but all have been invited—several times. Executive secretaries will be invited to a special program this fall.

An area of great frustration has been the Council's effort to attract non-member physicians to county and state society membership. The Council will be pressing such a campaign this fall but it doubts that anything short of sustained personal contact is going to produce significant results.

In the area of rural health, the Council assisted in the National Conference on Rural Health held by the AMA in Philadelphia in May, 1969, and it has increased the activities of its Physician Placement Service to attempt to meet medical coverage needs in geographically isolated sectors. Five physicians were placed in the first five months of the year.

Film library use has increased. The library is a limited one, with films limited to health careers and drug addiction. The variety of films deliberately has been restricted because of the easy access to films through the AMA and other organizations.

Exhibits on quackery were presented during the 1969 State Farm Show in Harrisburg for its 500,000 visitors and a variety of tabletop exhibits have been presented on other subjects at various places.

The Council, impressed with the voluntary efforts of physicians under various national and international programs, is asking the House of Delegates to adopt a specific commendation statement.

The Council hopes that this summary will prompt a reading of its full annual report where the above items, along with many other activities, are explained more fully. The full report will appear in the Official Reports Booklet and additional copies are available to any PMS member upon request. Above all, the Council invites your comments and suggestions concerning its responsibilities.

GOVERNMENTAL RELATIONS

The Council on Governmental Relations reports that much of its program, because this is a first year of a two-year legislative session for both Congress and the Pennsylvania Legislature, cannot be reported at this time. It does suggest that most of the legislation in which medicine is interested is "in the mill."

The Council reports on resolutions referred to it at the last session of the House, and points out that it feels that its major mission is providing physicians with more immunity from legal liability in view of the malpractice climate. It reports that the major bill on its calendar at the present time is House Bill 459 which would clarify the matter of informed consent. The Council also reports on other matters of interest to the House including Uniform Anatomical Gifts and a Medical Examiner System, and promises a supplemental report on legislative happenings closer to the Annual Session of the House of Delegates.

MEDICAL SERVICE

The following report is a summary of the most significant activities and actions of the Council on Medical Service during the past year.

The Council:

- Continued to assist and advise Pennsylvania Blue Shield in the development and expansion of the Prevailing Fee Plan.

- Provided continuing consultation to Pennsylvania Blue Shield with respect to their role as carrier for Medicare, Part B, CHAMPUS, and as fiscal administrator for Pennsycare.

- Assisted in the development and functioning of Regional Blue Cross Physician Advisory Committees which are organized to evaluate hospital utilization problems presented by Blue Cross Plans.

- Assisted in the preparation and presentation of testimony for several public hearings called by the State Insurance Department relative to Blue Cross rate increase requests.

- Developed a proposal for reorganization of the Blue Cross Review Program for Western Pennsylvania by setting up the PMS-Blue Cross Regional Steering Committee.

- Requested the specialty societies in Pennsylvania to nominate members to serve on specialty advisory committees organized under the Council to evaluate disputed fee cases and utilization problems presented by third party carriers.

- Continued to improve the Society's Review Program for handling disputed fee cases and utilization problems by reorganizing the Review Program in conformity with the provisions of the Pennsylvania Medical Care Program and in accordance with action taken by the 1968 House of Delegates.

- Met with representatives of various governmental agencies and Medicare carriers in an effort to improve liaison and developing a better understanding of the Society's review activities.

- Provided liaison with the Pennsylvania Department of Health's Office of Medicare regarding problems encountered with the Tenth Councilor District Central Review Plan for Extended Care Facilities.

- Participated in meetings with representatives of the Department of Public Welfare in an effort to seek improvements in the Pennsycare program and submitted statements to the Chairmen of the Senate and House Appropriation Committees of the Pennsylvania Legislature to outline the State Society's position.

- Continued to study the complex problems confronting practicing physicians in the area of malpractice insurance and to assist members in obtaining such coverage, upon request.

- Conducted a Malpractice Insurance Survey of the entire membership and made this survey available to the Pennsylvania Insurance Commissioner to assist his department in preparing for the April 2, 1969, meeting on malpractice insurance at which the State Society was represented.

- Assisted in developing a reporting format for county medical societies regarding Public Law 89-749 (Comprehensive Health Planning and Public Health Service Amendments of 1966) by utilizing members of the Commission on Comprehensive Health Planning to serve as areawide representatives for county societies.

- Continued to assist members and interested agencies throughout the State in the development of comprehensive health planning activities and provided liaison with the State Office for Comprehensive Health Planning.

- Maintained close surveillance over Society endorsed insurance programs.

EDUCATION AND SCIENCE

The following is a summarization of Council activities:

The Council presented an Officers' Conference program on "Innovations in Continuing Education."

The Council undertook a pilot closed-circuit television demonstration of an interhospital surgical/pathological conference, and also expressed interest in the use of public educational television through the newly formed Pennsylvania Television Network Commission.

In cooperation with PENNSYLVANIA MEDICINE, the Council has been exploring with a pharmaceutical firm and a medical school, development of a Disc-o-Tech—a tear-out record to be inserted into PENNSYLVANIA MEDICINE.

Upon invitation, the Council participated in a review of a provisional draft for new standards by the Joint Commission on Accreditation of Hospitals.

With the development of the regional medical programs and their move from planning to operational phase, the Council established liaison with the three Pennsylvania-based RMP's.

The Council appointed three members to meet with three members of the Pennsylvania Osteopathic Association to discuss mutual concern in continuing medical education.

The Council received approval to have established a fund within the Educational and Scientific Trust to finance educational activities sponsored by the Council. The Society gave an initial gift of $10,000.

Plans are under way to have the Pennsylvania Health Conference in Harrisburg, June 15-16, 1970.

The Pennsylvania Committee on Smoking and the Health of Youth, of which the Society is a member, held a very successful Education Week on Smoking and Health in January. Program activities reach three major areas: college and high school student conferences, county councils on smoking and health of youth, and teacher conferences.

The Pennsylvania Heart Coordinating Committee discontinued the Heart Association "Medical Datelines" publication with the understanding that everything in the cardiovascular field would be incorporated in the Council's Continuing Education Listing.

Pennsylvania Cancer Coordinating Committee is of the opinion that the most effective means of reducing cancer deaths is to promote programs in anti-smoking, uterine cytology, proctosigmoidoscopy and breast self-examination.

The Council investigated a proposal, known as Project Ketch, to utilize a nuclear explosion to create an underground storage cavity for gas in Central Pennsylvania. The Council was satisfied that adequate safeguards were being undertaken by the Commonwealth to protect the public in evaluation of this project.

Pennsylvania Board on Improvement of Health Care in Nursing Homes and Related Facilities is now engaged

in a study of the licensing and registration of nursing home administrators.

A new adventure for the Council has been providing staff service to the Pennsylvania Psychiatric Society. A Council staff member devoted 30 per cent of his time as executive secretary to the Society. The service is provided on a remuneration basis for services rendered.

The continued interest in organ transplantation caused the Council to gather data from medical schools, general hospitals, and voluntary health agencies on their position regarding organ transplant operations.

ENVIRONMENTAL HEALTH—Commission reviewed "Regulations for Certain Dangerous Substances" which were promulgated by the Division of Occupational Health of the State Department of Health.

The Commission received a letter of inquiry from the Ontario Medical Association in regard to pollution of Lake Erie. The Ontario Medical Association has asked eight state medical societies to seek greater enforcement powers for the International Joint Commission to curb Great Lakes pollution which at present has no power to act.

A letter of inquiry regarding the disposal of solid wastes from the metropolitan communities in abandoned strip mines was received. It was suggested that before county societies take a position, the Department of Health should be requested to determine whether the areas are suitable for sanitary landfills. The Commission was represented at several hearings concerning air and water pollution problems.

Presentations of the 1968 Occupational Health Awards were made to McNeil Laboratories, Inc., Westmoreland Hospital, and Sharon Steel Corporation.

GERIATRICS—Commission concentrated its efforts in four specific areas:

- The Elder Driver: A pilot project to compile rules and regulations of all states governing licensing of elderly drivers; general concepts of driver insurance coverage by age, sex, etc.; research investigation of traffic safety on the basis of age alone.
- Regional Faculties in Geriatric Training: A formal course on geriatrics throughout the State.
- Extended Care Facilities.
- Information and Referral Services for the Aging in Pennsylvania: A proposal envisioning the creation of telephone services where an inquiring person, family or agency could get complete information as to what is available for an aging person in the area.

MATERNAL AND CHILD HEALTH—Activities have been concentrated in two specific areas:

- The Tenth Annual Institute on Maternal and Child Health with the largest attendance ever.
- A Task Force on Pre-School Survey of Vision and Hearing engaged in the preparation of a Source Book identifying hearing-vision screening facilities available in Pennsylvania.

MENTAL HEALTH AND MENTAL RETARDATION—A Commission representative attended a meeting of administrators and county board members from Comprehensive Mental Health and Mental Retardation Programs to discuss the inclusion of a prevention program in the comprehensive plans. The Commission reviewed and endorsed three film documentaries on narcotics.

Testimony was given before a Senate investigating committee exploring the possibility of making codeine cough syrups a prescription item.

The Right to Treatment Bill, which would adopt minimum standards for treatment in mental hospitals, and the Peonage Bill, which would provide for remuneration of services rendered by mental hospital patients, were again introduced in the Pennsylvania Legislature. The Society's position was in thorough consonance with adoption of minimum standards of treatment and in support of the intent of the remuneration bill.

In response to Resolution No. 68-16 from the 1968 House of Delegates, the Commission has prepared a position statement on hypnosis for consideration by the House of Delegates.

SCHOOL HEALTH—The Commission has supported the Pennsylvania Department of Health's efforts to promote examinations by family physicians of every child.

Members have helped develop the Adapted Physical Education guidelines and helped prepared guidelines for Curriculum Development in Health Education, scheduled to be distributed this fall.

The Society actively supported legislation amending the Child Labor Law to permit the family physician or the physician of the prospective employer to complete the report of the physical examination required for issuance of working certificates.

Support was given the Inter-Agency Planning Committee, which sponsors Community-School Health Education Workshops.

Society representatives have been cooperating with the Pennsylvania High School Football Coaches' Association securing medical speakers for regional sports clinics and participating in a State Clinic.

ADVISORY COMMITTEE ON EMERGENCY MEDICAL SERVICE—Major concern continues to be the undeniable fact that, at the present time, there is no organized or coordinated Emergency Medical Service in Pennsylvania. Many meetings have been held to plot a statewide EMS program covering four major areas: organization, communications, transportation and emergency room facilities.

The Advisory Committee has recommended a survey of emergency room facilities in all hospitals.

In the past year, nine "Courses in Emergency Room Techniques" were presented around the State. In addition, through funds provided by The Philadelphia Foundation to the Educational and Scientific Trust of the Pennsylvania Medical Society, abbreviated emergency room courses were given at Brookville Hospital and Bloomsburg Hospital.

The Pennsylvania State Committee on Trauma of the American College of Surgeons was reconstituted and has assumed the responsibility of developing and supervising future "Courses in Emergency Room Techniques."

Emergency room courses are to be held this fall and next spring. Tentative places are: Lock Haven, DuBois, Lewistown, Chambersburg, Hazleton, and Meadville. Particular emphasis will be placed on malpractice and the medical-legal aspects in the ER, future criteria for ER departments, and pediatric and surgical orthopedic emergencies.

ADVISORY COMMITTEE ON MANPOWER—In support of Resolution 68-21, Preceptorship Programs, the Committee recommended that PMS seek funds for stipends to support the Pennsylvania Academy of General Practice

preceptorship program. The Committee also was authorized to seek a meeting with deans of medical schools to consider appropriate training needs of the family physician of the future.

The Educational Testing Service of Princeton, New Jersey, has been approached to see if they would be interested in developing and exploring new criteria (in lieu of diploma requirements) for the selection of practical nurse trainees.

The Committee recommend a change in the policy position of the Society from favoring licensing of paramedical personnel to the certification of such groups, utilizing nationally recognized certification programs.

The Committee prepared a written statement for the State Board of Education supporting the plan to implement the Vocational Education Amendments of 1968, provided sufficient money and staff was allocated to help satisfy the demands for health manpower.

ADVISORY COMMITTEE ON SCIENTIFIC SESSION—The Committee planned the 1969 Scientific Session around the theme "Clinical Therapeutics—1969." The schedule was arranged so that the seminars planned by the Committee would be held each morning over a period of four days. The afternoon time periods would be available for meetings of the various specialty societies. This innovation in scheduling was well received by the specialty society representatives and seventeen organizations have either planned their own programs or joined with other specialty societies to plan a program for the September meeting.

Financing this program continues to be a problem. The Committee proposed to the specialty society representatives that a nominal fee be charged to all registrants. The only really successful portion of the Scientific Session has been the one-day seminar planned for nurses and allied professionals. In 1968, there were twice as many paid nurses' registrations as paid M.D. registrations. It is obvious that the Scientific Session is no longer an effective method of continuing medical education for the members of the Pennsylvania Medical Society.

COMMUNITY HOSPITAL COURSES—one of the new programs developed by the Council during the year was the continuing medical education courses in community hospitals. Three pilot programs were conducted in the spring of 1969 in Meadville, DuBois and alternating between Sunbury and Shamokin. Physicians of all ages participated in the sessions and the attendance was, for the most part, very good. The evaluation which was conducted at each site indicated that the faculty and material presented were excellent and there is great enthusiasm for more courses of this type.

In order to secure more information regarding educational needs and present programs being offered throughout the State, the Council conducted two surveys. The first survey was mailed to all physicians in the areas of the three pilot programs to determine:

1. the physician's interpretation of his own practice situation,
2. the educational methods he uses at present and methods he wishes were available, and
3. in what areas of medicine he needs the most continuing education.

The second survey was conducted through the president of the medical staff of each hospital on the educational opportunities which are available either in the institution or in the adjoining area of his staff participates in neighboring programs.

Plans are being made to continue the interim program for at least two more years. During the academic year 1969-70, the Council will present courses in twelve areas of the State using funds available from the Pennsylvania Division of the American Cancer Society, the Pennsylvania Steering Committee for Continuing Education in Psychiatry, and the remainder of monies contributed by the pharmaceutical companies. The Board of Trustees has further authorized the Council to prepare a request for funds from regional medical programs to cover the cost of presenting courses during the academic year 1970-71.

COUNCIL PLANS FOR 1969-1970

The role of the Pennsylvania Medical Society in continuing education is *to maintain a high level of professional competence in its membership.* Our present activity in continuing education should be *strong leadership,* and not competition with others whose goal is the same.

Motivation must be encouraged as a voluntary reaction within each individual. We must develop an awareness of professional competence, provide a means to identify problem areas, and ultimately attempt to furnish to each member a personal satisfaction through improved performance. The program to achieve these goals must be based in quality care review within the local hospital or practicing group.

Coordination: The mutiplicity and overlapping of continuing medical education programs already existing in Pennsylvania raise serious questions as to their effectiveness and as to the need for the State Society to inaugurate more programs. We will teach local-level teachers meaningful techniques and educational methods, assure the availability of programs of excellence and pertinence for all members, and assemble course data for the reference of all agencies providing programs.

The State Society will continue its leadership in the education of nurses and allied health professionals.

Many alternative systems are available to administer any programs of continuing medical education. After hours of discussion and study, we conclude that the Council on Education and Science should be structured to better reflect its primary change. The statewide specialty organizations, medical schools, allied health agencies and hospitals should be kept informed of our activities and should be asked to assist with both our motivation and coordination leadership. The funding of the administrative portions of the program should be the responsibility of the State Society, with funding for projects being a joint responsibility of PMS and others who are or can be interested. The staff should be augmented with a professional medical educator.

PENNSYLVANIA DELEGATION TO AMERICAN MEDICAL ASSOCIATION

As mandated by the 1968 PMS House of Delegates, the Pennsylvania Delegation introduced four resolutions during the Clinical Convention of the AMA held in Miami Beach, Florida, December 1-4, 1968, as follows:

1. Smoking.
2. New Uses of Old Drugs.
3. Priority for Adequately Financing the Medicaid Program.
4. International System of Highway Signs.

The delegation introduced two resolutions as follows:

1. Medical Education for National Defense.
2. Creation of Division of Public Affairs.

The delegation voted unanimously to nominate M. Louise C. Gloeckner, M.D., for Vice President of the AMA in July, 1969.

A Memorial Resolution concerning the demise of W. Benson Harer, M.D., was adopted by the AMA House of Delegates.

A supplemental summary will be submitted since the Annual Meeting of the AMA was not held until July, 1969.

consistently scored high in degree and duration of intragastric buffering

Employing aspiration of gastric juice, indwelling electrode, and/or Heidelberg telemetering capsule techniques,* studies involving 79 subjects with or without proven peptic ulcer disease compared intragastric buffering capacity of Gelusil-M and 1 or the other or both of 2 leading ethical antacids, using comparable doses.*

All three antacids raised the pH above 3.5, an accepted criterion for antacids. The amount of time above this pH helps to characterize the buffering activity of an antacid. While it is not implied that a direct therapeutic correlation exists, these techniques do, however, objectively demonstrate the buffering characteristics of this new antacid in terms of onset of action, peak pH, duration of buffering action.

Mean peak pH*

Gelusil-M, mean peak pH 6.6 (range: 5.6-7.8).
Antacid A, mean peak pH 5.5 (range: 4.2-7.5).
Antacid B, mean peak pH 5.5 (range: 4.4-6.3).

Mean duration of buffering action above pH 3.5*

Gelusil-M, 29.8 mean minutes (range: 18.0-51.8 minutes).
Antacid A, 24.6 mean minutes (range: 6.3-48.0 minutes).
Antacid B, 23.3 mean minutes (range: 5.9-50.0 minutes).

Mean duration of buffering action above pH 5.0*

Gelusil-M, 23.2 mean minutes (range: 14.3-43.9 minutes).
Antacid A, 10.1 mean minutes (range: 6.7-12.2 minutes).
Antacid B, 16.3 mean minutes (range: 8.0-24.2 minutes).

Onset of action*

In speed of intragastric buffering action, Gelusil-M, Antacid A, and Antacid B were consistently rapid and not measurably different.

*References: Antacid studies, data on file, Warner-Chilcott Laboratories Division.

introducing new GELUSIL®-M

each 5 ml. teaspoonful contains:
500 mg. magnesium trisilicate, 250 mg. aluminum hydroxide (Warner-Chilcott), 200 mg. magnesium hydroxide
U.S. Patent No. 3,326,755

a consistent buffering anticostive† antacid

† Avoids constipation.

See next page for prescribing information ►

GELUSIL–one name to remember...and a dosage form for every patient.

Gelusil®-M Liquid

especially for the constipation-prone patient

Indications: Gelusil-M is indicated for prompt and dependable symptomatic relief of peptic ulcer, gastritis, heartburn, hiatal hernia, esophagitis, and other conditions for which control of gastric hyperacidity is required.

Precaution: Prolonged or intensive therapy in patients with severe renal insufficiency may lead to hypermagnesemia.

Dosage: One to two teaspoonfuls (5 ml. to 10 ml.) between meals and at bedtime or whenever symptoms occur. Certain conditions, such as acute peptic ulcer, may require individualized dosage. If diarrhea occurs, reduce dosage or discontinue use.

Supplied: Gelusil-M (spearmint-flavored)—light green bottles of 12 fl. oz.; and a **special hospital pack.** Keep tightly closed—shake vigorously.

Gelusil® Tablets

a universal take-along antacid

Easy to take along / easy to take / pleasantly mint-flavored. An antacid with adsorbent and demulcent properties which contains in one tablet: 0.25 Gm. aluminum hydroxide (Warner-Chilcott) and 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 tablets—or more—between meals and at bedtime, or whenever symptoms occur. Tablets should be chewed.

Regular Gelusil® Liquid

when constipation is not a problem

Pleasant mint flavor...ideal for hospital or home. Available in 12 fl. oz. and 6 fl. oz. bottles and a special hospital pack. An antacid which contains adsorbent and demulcent agents in each 4 ml. teaspoonful: 0.25 Gm. aluminum hydroxide (Warner-Chilcott), 0.5 Gm. magnesium trisilicate (USP).

Dosage: 2 teaspoonfuls (4 ml. each)—or more—between meals and at bedtime, or whenever symptoms occur.

Also Available: Gelusil® Flavor-Pack, Gelusil-Lac®.

WARNER-CHILCOTT
Morris Plains, New Jersey

GM-IN-93-4C

A list of educational opportunities offered to physicians in the interest of maintaining their competence and skill. Unless otherwise indicated, all courses are designed for physicians engaged in primary patient care.

ADOLESCENTS' MEDICAL CARE

February 26, 1970; York Hospital

I/AMA—**Occurrence and Genesis of Abnormal Menstruation at Puberty** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

ARTHRITIS AND RHEUMATISM

October 14, 1969; Chester

I/AMA—**Clinical Evaluation of the Inflamed Joint Including Synovial Analysis** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 12, 1969; Philadelphia

C—**The Painful Shoulder and Painful Back;** at Albert Einstein Medical Center; 6 hours AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Chmn., Educ. Comm., AEMC, York & Tabor Roads, Philadelphia 19141.

February 11, 1970; Philadelphia

C/AMA—**Rheumatoid Arthritis;** at Albert Einstein Med. Center; 6 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Med. Center, York & Tabor Rds., Philadelphia 19141.

CARDIOVASCULAR DISEASE

September 18, 1969; York Hospital

I/AMA—**Considerations on Cardiogenic Shock and Disturbances of Rhythm in the Patient with Infarction** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

September 26, 1969; Philadelphia

C—**Cardiopulmonary Resuscitation Instructors' Training Course;** by Pa. Heart Assoc., Jefferson and Heart Assoc. of Southeastern Pa.; at Jefferson. $15 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 7, 1969; Carlisle

C—**Diet in Cardiovascular Disease—Current Research and Practical Applications;** by Pa. Heart Assoc., Pa. Dietetic Assoc., Pa. Dept. of Health and South Central Pa. Heart Assoc.; at Embers Motel. $7 fee (includes lunch). Contact South Central Pa. Heart Assoc., 2915 Wayne St., Harrisburg 17111.

"CODE KEY"

C—Consecutive days
I—Intermittent
O—Circuit
PG—Postgraduate Traineeship
R—Radio
TV—Television
S—Designed for full-time specialists
AMA—AMA Accredited Institution
C E S—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Penn-Grad—University of Pennsylvania, Division of Graduate Medicine
Pitt—University of Pittsburgh School of Medicine
Pitt P.H.—University of Pittsburgh Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania School of Medicine
Woman's—Woman's Medical College of Pennsylvania

October 8, 1969; Wilkes-Barre

I/AMA—**Coma and Treatment of Myocardial Infarction and Its Complications** (Program of Continuing Medical Education—6 Wednesdays in September and October); by Hahnemann; at Wyoming Valley Hospital, 2 hrs. Contact David W. Kistler, M.D., Director, Wyoming Valley Hospital, 149 Dana St., Wilkes-Barre 18702.

October 8, 1969; Wilkes-Barre

C—**Diet in Cardiovascular Disease—Current Research and Practical Applications;** by Pa. Heart Assoc., Pa. Dietetic Assoc., Pa. Dept. of Health and Northeastern Pa. Heart Assoc. at Tredway Inn. $7 fee (includes lunch). Contact Northeastern Pa. Heart Assoc., 71 N. Franklin St., Wilkes-Barre 18701.

October 9, 1969; Philadelphia

C—**Diet in Cardiovascular Disease—Current Research and Practical Applications;** by Pa. Heart Assoc.; Pa. Dietetic Assoc., Pa. Dept. of Health and Heart Assoc. of Southeastern Pa.; at Jefferson. $7 fee (includes lunch). Contact Heart Assoc. of Southeastern Pa., 318 South 19th St., Philadelphia 19103.

October 15, 1969; Pittsburgh

C—**Diet in Cardiovascular Disease—Current Research and Practical Applications;** by Pa. Heart Assoc., Pa. Dietetic Assoc., Pa. Dept. of Health and Western Pa. Heart Assoc.; at Holiday House, Monroeville. $7 fee (includes lunch). Contact Western Pa. Heart Assoc., 709 House Bldg., 4 Smithfield St., Pittsburgh 15222.

October 16, 1969; Erie

C—**Diet in Cardiovascular Disease—Current Research and Practical Applications;** by Pa. Heart Assoc., Pa. Dietetic Assoc., Pa. Dept. of Health and Northwestern Pa. Heart Assoc.; at Shrine Club. $7 fee (includes lunch). Contact Northwestern Pa. Heart Assoc., 902 Diamond Park, Meadville 16335.

October 22, 1969; Harrisburg Hospital

C—**Cardiopulmonary Resuscitation Instructors' Training Course;** by Pa. Heart Assoc., Harrisburg Hosp. and South Central Pa. Heart Assoc. $15 fee. Contact Pa. Heart Assoc., Box 2435, Harrisburg 17105.

October 28, 1969; Chester

I/AMA—**Pulmonary Heart Disease** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 28, 1969; Johnstown

I/AMA—**The Coronary Care Unit** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 29, 1969; Wilkes-Barre

I/AMA—**Bedside Cardiology** (Program of Continuing Medical Education—6 Wednesdays in September and October); by Hahnemann; at Wyoming Valley Hospital, 5 hrs. Contact David W. Kistler, M.D., Director, Wyoming Valley Hospital, 149 Dana St., Wilkes-Barre 18702.

November 4, 1969; Chester

I/AMA—**The Office Management of Hypertension** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 6, 1969; Pottsville Hospital

I/AMA—**When to Operate for Hypertension** (Program of Continuing Medical

continuing education

Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 18, 1969; Chester

I/AMA—**Innocent Murmurs—Don't Make Them Cardiac Cripples** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 20, 1969; Altoona Hospital

I/AMA—**Myocardial Infarction, Consecutive Case Conference** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 9, 1969; Chester

I/AMA—**Clinical Applications of Cardiac Catherization** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Wilkes-Barre General Hospital

I/AMA—**Acute Stroke Syndrome** (Program of Continuing Medical Education—One Thursday Each Month); by Jefferson & Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Associate Dean, Jefferson, 1025 Walnut St., Phila. 19107.

January 8, 1970; Allentown Hospital

I/AMA—**Heart Sounds** (Program of Continuing Medical Education, 2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 27, 1970; Chester

I/AMA—**Anticoagulants in Cardiovascular Disorders** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; York Hospital

I/AMA—**New Concepts in Cardiac Surgery** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

March 19, 1970; Williamsport Hospital

I/AMA—**Coronary Artery Disease; Pre-Infarction and Post-Infarction. Problems of Recognition and Management** (Postgraduate Seminars held 3rd Thurs. ea. mo.); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 21, 1970; Wilkes-Barre General Hospital

I/AMA—**Drugs and the Heart** (Program of Continuing Medical Education —One Thursday each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

CHEST DISEASES

September 10, 1969; Wilkes-Barre

I/AMA—**Pulmonary Embolism and How to Evaluate Pulmonary Function** (Program of Continuing Medical Education—6 Wednesdays in September and October); by Hahnemann; at Wyoming Valley Hospital; 2 hrs. Contact David W. Kistler, M.D., Director, Wyoming Valley Hospital, 149 Dana St., Wilkes-Barre 18702.

October 16, 1969; Williamsport Hospital

I/AMA—**Clinical Pulmonary Physiology and Its Relation to Treatment** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 23, 1969; York Hospital

I/AMA—**New Theory and Approaches to Bronchial Asthma** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 10-21, 1969; Philadelphia (Repeat February 9-20, 1970 and April 6-17, 1970)

PG/AMA—**Postgraduate Course in Bronchoesophagology;** at Temple; for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. $350 fee. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

February 4—March 25, 1970; Philadelphia

I/AMA—**Diagnosis and Management of Chronic Respiratory Disease** (Each Tuesday—8 weeks); at Albert Einstein Medical Center; 20 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

March 17, 1970; Chester

I/AMA—**Pulmonary Infiltrates: TB or Not TB?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 24, 1970; Chester

I/AMA—**The Use and Abuse of Oxygen Therapy** (Program of Continuing Medical Education Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 31, 1970; Chester

I/AMA—**The Solitary Pulmonary Nodule;** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

DERMATOLOGY

September 25 to December 4, 1969 (10 Thursdays); Philadelphia

I—**Dermatology;** at Albert Einstein Medical Center; 25 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Chmn., Educ. Comm., AEMC, York & Tabor Roads. Philadelphia 19141.

November 20, 1969; Williamsport Hospital

I/AMA—**Office Management of Common Dermatologic Problems;** (Postgraduate Seminars held 3rd Thurs. ea. mo.); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 16, 1970; York Hospital

I/AMA—**Dermatologic Drug Reactions and Their Pathophysiology** (Program of Continuing Medical Education —Each Thursday, 30 weeks); by Jeffer-

son and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

ELECTROCARDIOGRAPHY

October 8, 1969 to January 28, 1970 (14 Wednesdays); Philadelphia

I—**Basic Electrocardiography;** at Albert Einstein Medical Center; 42 hrs. AAGP credit; $100 fee. Contact Solomon Mintz, M.D., Chmn., Ed. Comm. AEMC, York & Tabor Roads, Philadelphia 19141.

February 25—April 29, 1970; Philadelphia

I/AMA—**Advanced Electrocardiography;** Each Tuesday, 10 weeks; at Albert Einstein Medical Center, 30 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

ENDOCRINOLOGY

January-May, 1970 (3rd Thurs. ea. mo.); Bethlehem

I—**Endocrinology: Medical and Surgical Aspects;** at St. Luke's Hosp., by Jefferson; 24 hrs. AAGP credit; $24 fee (6 seminars), $7 ea. Contact Michael L. Sheppeck, M.D., Med. Dir., St. Luke's Hosp., Bethlehem 18015.

January 15, 1970; Bethlehem;

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Pituitary Gland;** (Program of Continuing Medical Education); By Jefferson and Penn State at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

February 3, 1970; Chester

I/AMA—**The Problem Diabetic** (Program of Continuing Medical Education —Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 10, 1970; Chester

I/AMA—**Thyroid Function Tests—How to Evaluate Them** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D. M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 17, 1970; Chester

I/AMA—**Thyroid Nodule—When Not to Operate** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Thyroid Gland.** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital, 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia.

February 24, 1970; Chester

I/AMA—**The Outpatient Management of Anemia** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 4, 1970; Chester

I/AMA—**Enigma of Hypoglycemia** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Parathyroid Gland.** (Program of Continuing Medical Education) by Jefferson & Penn State at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Phila. 19107.

March 26, 1970; York Hospital

I/AMA—**What's New in Endocrinology** (Program of Continuing Medical Education—Each Thursday, 3 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 16, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Adrenal Gland** (Program of Continuing Medical Education) by Jefferson and Penn State; at St. Luke's Hospital, 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Phila. 19107.

April 28, 1970; Johnstown

I/AMA—**Obesity** (Program of Continuing Medical Education—Last Tuesday—7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 7, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Ovary** (Program for Continuing Medical Education); by Jefferson and Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 21, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Tumors of Nonendocrine Origin** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Phila. 19107.

GASTROENTEROLOGY

September 16, 1969; Chester

I/AMA—**Hepatitis** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 1, 1969; Philadelphia

C—**Symposium on the Differential Diagnosis of Jaundice;** at Nazareth Hospital; 5 hrs. AAGP credit applied for. Contact Charles A. Syms, M.D., Nazareth Hospital, 2601 Holme Avenue, Philadelphia 19152.

February 19, 1970; Williamsport Hospital

I/AMA—**Dilemmas of a Belly Ache** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 9, 1970; Allentown Hospital

I/AMA—**Ulcerative Colitis** (Program of Continuing Medical Education, 2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 14, 1970; Chester

I/AMA—**Inflammatory Diseases of the Bowel** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 21, 1970; Chester

I/AMA—**The Irritable Colon Syndrome and Diverticular Disease of the Colon** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 29, 1970; Chester

I/AMA—**Immunoglobulins and the GI Tract** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

GENERAL MEDICINE

Every Thursday; Hazleton State General Hospital

I—**Program of Continuing Medical Education by Hazleton Branch, Luzerne County Medical Society.** Contact Robert Gunderson, M.D., Suite 412 Northeastern Building, Hazleton, Pa. 18201.

September 11, 1969; Allentown Hospital

I/AMA—**Metabolic Causes for Renal Calculus** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

September 12, 1969—Williamsport Hospital

I/AMA—**Fevers of Unknown Origin in a Pediatric Population** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP Credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

September 15-18, 1969; Lancaster

C—**"Clinical Therapeutics—1969";** by C E S; at Host Farm Resort Motel. Fee: $10. Contact John H. Killough, M.D., PMS—Taylor Bypass and Erford Rd., Lemoyne 17043.

September 18, 1969; Bethlehem

I/AMA—**Immunology: Basic Concepts** (Program of Continuing Medical Education) by Jefferson and Penn State; at St. Luke's Hospital; 3 hrs. AAGP Credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

September 23, 1969; Chester

I/AMA—**Laboratory Aids in Office Practice** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

September 25, 1969; York Hospital

I/AMA—**The Pathophysiology and Rational Therapy of Shock** (Program of Continuing Medical Educational—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 2, 1969; Pottsville Hospital

I/AMA—**Preoperative Evaluation to Prevent Postoperative Complications** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 2, 1969; Altoona Hospital

I/AMA—**Obstetric and Gynecologic Endocrinology** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 7, 1969—March 3, 1970; East Stroudsburg

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—First Tuesday each month, 6 sessions); by C E S; at Monroe County General Hospital; 18 hrs. AAGP credit applied for; $25 fee ($8 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 8, 1969—May 13, 1970; Somerset Community Hospital

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Second Wednesday each month, 6 sessions); by C E S; 18 hrs. AAGP credit applied for; $25 fee ($8 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 9, 1969; Allentown Hospital

I/AMA—**Diabetes** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 9, 1969; Bethlehem

I/AMA—**Congenital Absence of the Thymus and Its Immunological Consequences** (Program of Continuing Medical Education) by Jefferson & Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 10, 1969; Williamsport Hospital

I/AMA—**Hepatitis;** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 15, 1969-December 3, 1969 (Wednesdays); Philadelphia

I/AMA—**Recent Advances in Medicine;** at Temple; 32 hrs. AAGP Credit; $50 fee. Contact Albert J. Finestone, M.D., Dept. of Med., Temple, Broad & Tioga Sts., Phila. 19140.

October 16, 1969; Altoona Hospital

I/AMA—**Hepatitis, Consecutive Case Conference** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

October 16, 1969; Wilkes-Barre General Hospital

I/AMA—**Disease of Laboratory Origin** (Program of Continuing Medical Education—One Thursday each month); by Jefferson & Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 16, 1969; York Hospital

I/AMA—**The Pathogenesis of Organic Disease in the Alcoholic** (Program of Continuing Medical Educaiton—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 21, 1969—May 19, 1970; Bradford and Kane

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Third Tuesday each month, 6 sessions); by C E S; alternately at Bradford's Penn Hills Club and Kane Manor; 18 hrs. AAGP credit applied for; $25 fee ($8 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 22, 1969—April 1, 1970; Sharon General Hospital

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Alternate Wednesdays, 10 sessions); by C E S; 30 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 22, 1969—April 15, 1970; Meadville

I—**Current Medical and Surgical Con-**

cepts (Program of Continuing Medical Education—Alternate Wednesdays, 11 sessions); by C E S; at Spencer Hospital; 33 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 22, 1969—April 1, 1970; Uniontown Hospital

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Alternate Wednesdays, 10 sessions); by C E S; 30 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 23, 1969; Bethlehem

I/AMA—**Vascular Response to Altered Immunity** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 2, 1969; Philadelphia

C—**Third Annual J. Herbert Nagler Memorial Symposium;** by Philadelphia Academy of G.P.; at Holiday Inn; $10 fee; 6 hrs. AAGP credit. Contact Milton W. Perloff, M.D., 2923 W. Cheltenham Ave., Philadelphia 19150.

November 6, 1969; Altoona Hospital

I/AMA—**Medical and Surgical Approaches to Inflammatory Lesions of the Colon** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 11, 1969; Chester

I/AMA—**Principals of Cerebral Localization** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 13, 1969; York Hospital

I/AMA—**Recent Advances in Treatment of Renal Calculi** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 14, 1969; Williamsport Hospital

I/AMA—**Hormonal Contraceptives—Indications and Contraindications** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 20, 1969; Bethlehem

I/AMA—**Immunologic Basis of Hematologic Diseases** (Program of Continuing Medical Education); by Jefferson & Penn State; At St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 20, 1969; York Hospital

I/AMA—**Pulmonary Reserve, Body Habitus, and Anesthesia Risk** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 4, 1969; Altoona Hospital

I/AMA—**Innocent Murmurs in Children;** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 4, 1969; Pottsville Hospital

I/AMA—**The Pill—More Than the Answer to a Maiden's Prayer** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 9-12, 1969; Philadelphia

C/AMA—**Emergencies in Medical Care;** by Hahnemann; at Marriott Motor Hotel; 56 hrs. AAGP credit applied for; $150 fee—paramedics $35. Contact Stanley Spitzer, M.D. or Wilbur W. Oaks, M.D., Hahnemann, 230 North Broad St., Philadelphia 19102.

December 12, 1969; Williamsport Hospital

I/AMA—**Current Concepts of Thyroid Disease** (Program of Continuing Medical Education 2nd Fri. each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 15, 1969; Johnstown

I/AMA—**Drug Reactions** (Program of Continuing Medical Education—3rd Monday—7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Altoona Hospital

I/AMA—**Approach to the Patient with Fever of Unknown Origin** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Bethlehem

I/AMA—**Immunologic Basis for Drug Reactions** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital, 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 8, 1970; Pottsville Hospital

I/AMA—**Chronic Leg Ulcers** (Program of Continuing Medical Education—1st Thursday Each Month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

January 15, 1970; Altoona Hospital

I/AMA—**Newer Diagnostic Techniques in Radiology** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

February 5, 1970; Altoona Hospital

I/AMA—**Current Theories Concerning Causation of Cancer** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

February 5, 1970; Pottsville Hospital

I/AMA—**Hepatitis** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 5—April 16, 1970; DuBois Hospital

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Alternate Wednesdays, 11 sessions); by C E S; 33 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

February 5, 1970; York Hospital

I/AMA—**What's New in Antibiotics and Cardiac Drugs** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 12, 1970; Allentown Hospital

I/AMA—**Early Diagnosis of the**

continuing education

Stroke Prone Patient (Program of Continuing Medical Education—2nd Thursday, each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 12, 1970; York Hospital

I/AMA—**Pathophysiology of Hepatic Failure** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 13, 1970; Williamsport Hospital

I/AMA—**Surgical Aspects of Venous and Arterial Insufficiency of the Lower Extremities** (Program of Continuing Medical Education—2nd Friday of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Altoona Hospital

I/AMA—**Hyperlipodemias** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Wilkes-Barre General Hospital

I/AMA—**Clinical Application of Scanning Techniques** (Program of Continuing Education—One Thursday each month); by Jefferson & Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

March 5, 1970; Altoona Hospital

I/AMA—**Management of The Pregnant Diabetic** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

March 5, 1970; Pottsville Hospital

I/AMA—**Infections of the Central Nervous System** (Program of Continuing Medical Education 1st. Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia.

March 12, 1970; Allentown Hospital

I/AMA—**State of Renal Transplants** (Program of Continuing Medical Education, 2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 13, 1970; Williamsport Hospital

I/AMA—**The Physician's Role in Sex Education** (Program of Continuing Medical Education 2nd Fri. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Altoona Hospital

I/AMA—**Aggressive Management of Patients with Stroke** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

April 2, 1970; Altoona Hospital

I/AMA—**Emotional Problems at Adolescence** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

April 2, 1970; Pottsville Hospital

I/AMA—**Genetic Implications of Drugs and Radiation Exposure** (Program of Continuing Medical Education, 1st. Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 7, 1970; Chester

I/AMA—**Antibiotics—Uses and Abuses** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks; by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 16, 1970; Altoona Hospital

I/AMA—**Diagnosis of Anemia** (Program of Continuing Medical Education —twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 7, 1970; Altoona Hospital

I/AMA—**Short Course in Cardiac Auscultation** (Program of Continuing Medical Education—twice monthly); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 7, 1970; Pottsville Hospital

I/AMA—**Modern Management of Shock** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 14, 1970; Allentown Hospital

I/AMA—**Use of Antibiotics** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

June 4, 1970; Pottsville Hospital

I/AMA—**Thrombophlebitis—Incidence, Risks, Treatment** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

June 11, 1970; Allentown Hospital

I/AMA—**Advances in the Concepts of Chemotherapy** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

GENERAL

October 15-17, 1969; Pittsburgh

C—**Emphasis on Patient Discharge Planning** (Part II—Spotlight on Patient Discharge Planning); by Montefiore Hospital; at William Penn Hotel; $35 fee (includes 2 luncheons, 1 dinner). Contact M. F. Calvert, Training and Information Center, Montefiore Hospital, 3459 5th Ave., Pittsburgh 15213.

October 30-31, 1969; Philadelphia

C—**Blood Cells as a Tissue** (Sixth International Tissue Research Conference); at Lankenau Hosp. Contact William L. Holmes, Ph.D., Div. of Research, Lankenau, Lancaster & City Line Aves., Philadelphia 19151.

GENETICS

September 9, 1969; Chester

I/AMA—**Drug and Radiation Induced Chromosal Changes** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 11, 1969; Allentown Hospital

I/AMA—**Genetics** (Program of Con-

tinuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

November 12 and 13, 1969; Reading Hospital

C—**Two Days of Hematology;** AAGP credit applied for; $25 fee ($10 for interns, residents, fellows & students). Contact Charles J. Lusch, M.D., Reading Hospital, Reading 19602.

May 19, 1970; Chester

I/AMA—**The Hematologic Curse of Modern Drug Therapy** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 26, 1970; Chester

I/AMA—**Hematologic Manifestations of Systemic Disease** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact JoJhn H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

INTERNAL MEDICINE

September 17, 1969; Wilkes-Barre

I/AMA—**Current Concepts and Treatment of Shock** (Program of Continuing Medical Education—6 Wednesdays in September and October); by Hahnemann; at Wyoming Valley Hospital; 2 hrs. Contact David W. Kistler, M.D., Director, Wyoming Valley Hospital, 149 Dana St., Wilkes-Barre 18702.

September 18, 1969; Wilkes-Barre General Hospital

I/AMA—**Use and Misuse of Antibiotics** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 7, 1969; Chester

I/AMA—**Diuretics—Which One and How Often?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 15, 1969; Wilkes-Barre

I/AMA—**Recent Advances in the Laboratory** (Program of Continuing Medical Education—6 Wednesdays in September and October); by Hahnemann; at Wyoming Valley Hospital; 2 hrs. Contact David W. Kistler, M.D., Director, Wyoming Valley Hospital, 149 Dana St., Wilkes-Barre 18702.

October 21, 1969; Chester

I/AMA—**Cyclic Edema** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 20, 1969; Philadelphia

C/AMA—**Office Management of Diabetes and Its Complications;** at Albert Einstein Medical Center; 6½ hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

November 25, 1969; Chester

I/AMA—**Clinical Approach to Common Arrhythmias** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 16, 1969; Chester

I/AMA—**Clinical Problems in Acid-Base Balance** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 23, 1969; Chester

I/AMA—**The Initial Evaluation of the Patient with Renal Disease** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 8, 1970; York Hospital

I/AMA—**Concepts of the Pineal Gland in Menstruation** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 22, 1970; York Hospital

I/AMA—**Current Therapy of Fluid and Electrolyte Homeostasis** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

March 10, 1970; Chester

I/AMA—**Clinical Implications of New Discovered Hormonal Agents** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

MALIGNANT DISEASE

September 18, 1969; Williamsport Hospital

I/AMA—**New Ideas of Cancer Detection and Treatment** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107

October 22, 1969; Hotel Bethlehem

C—**Scientific Symposium on Cancer of the Head and Neck;** by American Cancer Society, Northampton County Unit; 7 hrs. AAGP credit applied for; $6 fee. Contact C. F. Snyder, M.D., President, Northampton County Unit, ACS, 802 High St., Bethlehem 18018.

MICROBIOLOGY & IMMUNOLOGY

September-December, 1969, (3rd Thurs. ea. mo.); Bethlehem

I—**Immunology;** at St. Luke's Hosp.; by Jefferson; 20 hrs. AAGP credit; $20 fee (5 seminars), $7 each. Contact Michael L. Sheppeck, M.D., Med. Dir., St. Luke's Hosp., Bethlehem 18015.

MENTAL RETARDATION

April 13-17, 1970; Elwyn

C—**Fourth Annual Symposium on Mental Retardation;** at Elwyn Institute; 7 hrs. each day; $25 fee. Contact Gerald R. Clark, M.D., President, Elwyn Institute, 111 Elwyn Rd., Elwyn 19063.

METABOLISM

October 30, 1969; York Hospital

I/AMA—**Metabolic Aspects of Weight Reduction** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 30, 1969; Chester

I/AMA—**The Problem of Hyponatremia** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Penn State and Jefferson; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

continuing education

January 6, 1970; Chester

I/AMA—**Aldosterone** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

NEUROLOGY

September 30, 1969; Chester

I/AMA—**The Subclavian Steal and other Neurological Thievery** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 8, 1970; Philadelphia

C/AMA—**Teaching Day in Neurology;** at Albert Einstein Medical Center; 6 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 19141.

OBSTETRICS & GYNECOLOGY

October 9, 1969; York Hospital

I/AMA—**Psychological Problems in the Postpartum Period** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 13, 1969; Allentown Hospital

I/AMA—**Diabetes and Pregnancy** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 2, 1969; Chester

I/AMA—**The Pill—More Than The Answer to a Maiden's Prayer?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 15, 1970; Wilkes-Barre General Hospital

I/AMA—**The Pill—More Than the Answer to a Maiden's Prayer?** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 11, 1970; Philadelphia

C/AMA—**Contraception and Management of the Infertile Couple;** at Albert Einstein Medical Center; 5 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 19141.

April 30, 1970; York Hospital

I/AMA—**Pathophysiology of Fallopian Tube Function** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

OPHTHALMOLOGY

April 15-17, 1970; Pittsburgh

C/S—**Ophthalmic Micro Surgery;** by Pitt; at Eye and Ear Hospital; 8 hrs. each day; $350 fee; Maximum registration—12. Contact Kenneth T. Richardson, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

April 20-22, 1970; Pittsburgh

C/S—**The Glaucomas;** by Pitt; at Eye and Ear Hospital; 8 hrs. each day; $150 fee; Maximum registration—20. Contact Kenneth T. Richardson, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

ORTHOPAEDICS

March 19, 1970; York Hospital

I/AMA—**Concepts of Bone Healing** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PEDIATRICS

October 2, 1969; York Hospital

I/AMA—**Management of Pulmonary Acid-Base Problems in Children** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs AAGP credit; $40 fee for 30 weeks ($8 each) Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 22-December 10, 1969; Philadelphia

I/AMA—**Recent Advances in Pediatrics;** at Jefferson; 8 Wednesdays; 16 hrs. AAGP credit applied for; $50 fee. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia, 19107.

November 20, 1969; Wilkes-Barre General Hospital

I/AMA—**Fevers of Unknown Origin in the Pediatric Age Group** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 11, 1969; York Hospital

I/AMA—**Selected Aspects of Neonatology** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; York Hospital

I/AMA—**The Delivery of Care to Pediatric Patients** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 18, 1969; Williamsport Hospital

I/AMA—**Urologic Problems in Children** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 29, 1970; York Hospital

I/AMA—**Present Concepts of Pediatric Immunology** (Program of Continuing Medical Education Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

March 12, 1970; York Hospital

I/AMA—**What's New in Infectious Diseases in Children** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 31, 1970; Johnstown

I/AMA—**Neonatal Respiratory Syn-**

dromes (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 12-15, 1970; Philadelphia

C—**19th Annual Pediatric Postgraduate Seminar;** at St. Christopher's Hospital for Children; 6 hrs. each day; $100 fee. Contact John B. Bartram, M.D., Director, Division of Service to Handicapped, St. Christopher's Hospital, 2600 N. Lawrence St., Philadelphia 19133.

PHYSIOLOGY

April 2, 1970; York Hospital

1/AMA—**Physiology of Renal Function, Revisited** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Associate Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

April 9, 1970; York Hospital

I/AMA—**The Physiology of Contractility and Cardiac Failure** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 9-11, 1970; Philadelphia

C/AMA—**Current Concepts in Physiology of the Gastrointestinal, Endocrine and Respiratory Systems;** by American College of Physiology and American Physiological Society; at Holiday Inn; $60 fee—ACP members ($100, nonmembers). Contact Daniel H. Simmons, M.D., Director, ACP, 4200 Pine Street, Philadelphia 19104.

April 23, 1970; York Hospital

I/AMA—**The Physiology of Acidosis** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

September 10—December 10, 1969; Scranton

I—**Common Emotional Problems in Medical Practice;** by the Institute of Pennsylvania Hospitals; at Community Medical Center-E; each Wednesday, 14 weeks; $25 fee. Contact Sydney E. Pulver, M.D., The Institute, 111 N. 49th St., Philadelphia 19139.

September 18—November 6, 1969; Harrisburg

I/AMA—**Basic Psychiatry in Medical Practice;** by Hahnemann; at Osteopathic Hospital—Each Thursday, 8 weeks. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

September 18—November 20, 1969; Harrisburg

I/AMA—**Emotional Problems in Medical Practice;** by Hahnemann; at Polyclinic Hospital—Each Thursday, 10 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

September 18, 1969—May 14, 1970; Lancaster

1/AMA—**Clinical Seminars in Medical Psychiatry** (Basic and Advanced); by Hahnemann; at Lancaster Osteopathic Hospital—Each Thursday, 30 weeks; 60 hrs. AAGP credit. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

September 24—November 26, 1969; Philadelphia

I/AMA—**Sexual Problems in Medical Practice;** at Hahnemann—Each Wednesday, 10 weeks. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 1—December 17, 1969; Philadelphia

I—**The Two Faces of Medicine: Postgraduate Psychiatry for Physicians;** at the Institute of Pennsylvania Hospital —Each Wednesday, 12 weeks; 48 hrs. AAGP credit; $50 fee. Contact Sydney E. Pulver, M.D., The Institute, 111 N. 49th St., Philadelphia 19139.

October 1, 1969—February 25, 1970; Philadelphia

I—**Medical Hypnosis;** at the Institute of Pennsylvania Hospital—Each Wednesday, 20 weeks; 80 hrs. AAGP credit; $250 fee. Contact Sydney E. Pulver, M.D., The Institute, 111 N. 49th St., Philadelphia 19139.

October 2—November 6, 1969; Philadelphia

I—**Depression and Suicide;** at the Institute of Pennsylvania Hospital—Each Thursday, 6 weeks; 18 hrs. AAGP credit; $25 fee. Contact Sydney E. Pulver, M.D., The Institute, 111 N. 49th St., Philadelphia 19139.

October 6—November 24, 1969; Philadelphia

S/1—**Therapy of Problems in Sexual Adjustment** (Continuing Education Program for Psychiatrists); at Institute of Pa. Hosp.; 8 weeks; $50 fee; registration deadline Sept. 15. Contact Gerald J. Margolis, M.D., Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

October 6—December 8, 1969; Philadelphia

S/I—**Behavior Therapy** (Continuing Education Program for Psychiatrists); at Institute of Pa. Hosp.; 10 weeks; $50 fee; registration deadline Sept. 15. Contact Gerald J. Margolis, M.D., Institute of Pa. Hosp., 111 N. 49th St., Phila. 19139.

October 6—December 8, 1969; Philadelphia

S/1—**Family Therapy;** (Continuing Education Program for Psychiatrists); at Institute of Pa. Hosp.; 10 weeks; $50 fee; registration deadline Sept. 15. Contact Gerald J. Margolis, M.D., Institute of Pa. Hosp., 111 N. 49th St., Phila. 19139.

October 8, 1969—March 25, 1970; Philadelphia

1/AMA—**Clinical Seminars in Child Psychiatry;** at Hahnemann—Each Wednesday, 23 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

Fourth Friday each month, September, 1969—June, 1970; Butler

1—**Physician-Community Psychiatrist Seminar;** by Mental Health Guidance Clinic of Butler Co.; at YWCA; Hour for hour AAGP credit. Contact Robert L. Eisler, M.D., Mental Health Guidance Clinic, 128 S. Main St., Butler 16001.

October 15, 1969—March 4, 1970; Philadelphia

I/AMA—**Psychiatric Problems of Children (Basic);** at Hahnemann—Each Wednesday, 18 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 22, 1969—March 18, 1970; Philadelphia

1—**Basic Office Psychiatry and Psychosomatic Medicine;** at Temple—Each Wednesday, 20 weeks; 80 hrs. AAGP credit; $50 fee. Contact Barney M. Dlin, M.D., Director, Department of Psychiatry, Temple, Broad and Ontario Sts., Philadelphia 19140.

October 22, 1969—January 7, 1970; Philadelphia

1/AMA—**Clinical Seminars in Medical Psychiatry (Advanced);** at Hahnemann—Each Wednesday, 10 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 22, 1969—June 3, 1970; Philadelphia

1/AMA—**Psychology of Medical Practice: Seminars in Psychotherapy;** at Hahnemann—Each Wednesday, 30 weeks; AAGP credit applied for $50 fee. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

November 6, 1969—January 8, 1970; Harrisburg Hospital

1/AMA—**Management of Psychiatric Problems in Medicine;** by Hahnemann—Each Thursday, 7 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

continuing education

November 12, 1969—January 28, 1970; Philadelphia

I—**Advanced Office Psychiatry and Psychosomatic Medicine;** at Temple—Each Wednesday, 10 weeks; 30 hrs. AAGP credit; $40 fee. Contact Barney M. Dlin, M.D., Director, Department of Psychiatry, Temple, Broad & Ontario Sts., Philadelphia 19140.

January 1, 1970 to February 11, 1970 (Each Wednesday); Philadelphia

I—**Depression and Suicide;** at Institute of Pa. Hosp., 18 hrs. AAGP credit. $25 fee. Contact Sydney E. Pulver, M.D., Program Director, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

January 14—March 18, 1970; Philadelphia

I/AMA—**Clinical Seminars in Medical Psychiatry (Advanced);** at Hahnemann—Each Wednesday, 10 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

February 18—May 13, 1970; Philadelphia

I—**Advanced Applied Office Psychiatry;** at the Institute of Pennsylvania Hospital—Each Wednesday, 12 weeks; 48 hrs. AAGP credit; $50 fee. Contact Sydney E. Pulver, M.D., The Institute, 111 N. 49th St., Philadelphia 19139.

February 24, 1970; Johnstown

I/AMA—**Psychotherapeutic Drugs** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 5, 1970; York Hospital

I/AMA—**Pathophysiology of Schizophrenia** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Wilkes-Barre General Hospital

I/AMA—**Battle of the Sexes—Is Marriage Worth Saving?** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 1—June 3, 1970; Philadelphia

I/AMA—**Clinical Seminars in Medical Psychiatry (Advanced);** at Hahnemann—Each Wednesday, 10 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

RADIOLOGY AND RADIOISOTOPES

November 25, 1969; Johnstown

I/AMA—**Current Status of Radio-Isotope Scanning** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 5, 1970; Chester

I/AMA—**The Use of Isotopes in Medicine** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 12, 1970; Chester

I/AMA—**Heavy Dose Irradiation—When Does it Palliate?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 26, 1970; Johnstown

I/AMA—**Newer Diagnostic Aspects in Radiology** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

SURGERY

December 4, 1969; York Hospital

I/AMA—**The Changing Techniques of Abdominal and Thoracic Surgery** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

January 15, 1970; York Hospital

I/AMA—**Present Concepts of Surgical Ulcer Treatment** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 18—March 25, 1970; Philadelphia

I/AMA—**Office Surgery;** Each Tuesday, 6 weeks; at Albert Einstein Medical Center; 18 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

UROLOGY

November 6, 1969; York Hospital

I/AMA—**When and What Kind of Prostatectomy** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

January 13, 1970; Chester

I/AMA—**Home Dialysis** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 20, 1970; Chester

I/AMA—**The Kidney, Bones and Stones** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson 1025 Walnut St., Philadelphia 19107.

March 18, 1970; Philadelphia

C/AMA—**Developments in Kidney Disease;** at Albert Einstein Medical Center; 6 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 19141.

April 16, 1970; Wilkes-Barre General Hospital

I/AMA—**Surgical Aspects of Inflammatory Diseases of the Bowel** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

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obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **John W. Hope,** Philadelphia; Stanford University School of Medicine, Palo Alto, Calif., 1940; age 54; died June 16, 1969. He was a member of a number of medical organizations, including the American Roentgen Ray Society and the American College of Physicians. He was professor of radiology at the University of Pennsylvania School of Medicine and director of radiology at Children's Hospital, Philadelphia. Survivors include his wife, a son and a sister.

○ **Irvin G. Klaus,** Melrose Park; University of Pennsylvania School of Medicine, 1924; age 68; died May 19, 1969. He served as chief of urology at Albert Einstein Medical Center until 1965 and was a past president of the Philadelphia Urological Association. He served in the Army Medical Corps during World War II. Survivors include his wife, a daughter, two sons, Robert L. Klaus, M.D. and Richard M. Klaus, M.D., two sisters and a brother.

○ **Moses J. Leitner,** East Stroudsburg; Long Island College of Medicine, 1932; age 60; died June 4, 1969. He was a fellow of the American College of Clinical Pathologists. Surviving are his wife, two daughters and two sisters.

○ **Catharine Macfarlane,** Philadelphia; Woman's Medical College, 1898; age 92; died May 27, 1969. Dr. Macfarlane was a pioneer among women in the field of medicine, and became an instructor at Woman's in 1899. She did graduate work here and abroad in urology and gynecology and in radiology. Dr. Macfarlane was the first to use radium in the treatment of cancer in the Philadelphia area, in the early 1900's and became a member of the American College of Surgeons in 1913. In 1938 through a grant from the American Medical Association, she established the first cancer prevention research clinic in Philadelphia. Through the years she received many honors and awards. She was the first woman to receive the Strittmatter Award, and received the Gimbel award in 1940 for her work in cancer research. There are no survivors.

○ **Norman Margolis,** Philadelphia; St. Mungo's Medical College, Glasgow, Scotland, 1942; age 57; died May 25, 1969. Survivors include his wife and two daughters.

○ **Louis Merves,** Philadelphia; Jefferson Medical College, 1937; age 56; died May 28, 1969. He was a member of the American Society of Internal Medicine and was assistant professor of clinical medicine at Jefferson. He is survived by his wife, two sons and a brother.

○ **Frank M. Pogue,** Trafford; Medico-Chirurgical College of Philadelphia, 1909; age 82; died June 8, 1969. He practiced medicine in Trafford for thirty-nine years, until his retirement in 1950. He served as a captain in the Army Medical Corps in World War I. Surviving are two sons, one of whom is Jackson S. Pogue, M.D.

○ **Edgar L. Rothfuss,** Williamsport; University of Pennsylvania School of Medicine, 1921; age 77; died May 28, 1969. He was a fellow of the International Academy of Proctology. Surviving are a sister and three brothers who are doctors: Paul Rothfuss, M.D., and B. C. Rothfuss, M.D., Williamsport, and Howard Rothfuss, M.D., Woodbridge, N. J.

○ **James M. Sherwood,** North Wales; University of Pennsylvania School of Medicine, 1953; age 47; died May 21, 1969. He is survived by his wife, three daughters, a son and his parents.

○ **William H. Spencer,** Washington, D. C., Jefferson Medical College, 1916; age 83; died May 14, 1969. Dr. Spencer practiced medicine in Philadelphia for nearly fifty years before his retirement in 1963. He was one of the founders of Doctors Hospital in Philadelphia in 1939. No survivors are named.

○ **Francis S. Tolodziecki,** Braddock; Hahnemann Medical College, 1938; age 56; died June 15, 1969. He had practiced internal medicine in Braddock since 1940. His wife and a sister survive.

○ **Vincent E. Wall,** Wynnewood; Hahnemann Medical College, 1948; age 43; died April 30, 1969. He is survived by his wife, two daughters, a son, his mother and a brother.

Francis P. Knight, Scranton; University of Pennsylvania School of Medicine; age 72; died May 28, 1969. Survivors include two daughters, two brothers and two sisters.

Jeanne L. Truter, Nashville, Tenn.; Women's Medical College, 1938; age 56; died May 26, 1969. She formerly was chief of the department of anesthesiology at Geisinger Medical Center. She is survived by her husband, Thomas K. Hepler, M.D., Nashville.

Andrew J. Merva, Nanticoke; Medical College of Virginia, Richmond, Va., 1929; age 69; died June 2, 1969. Survivors include his wife and sister.

○ **James Edward Topper,** Windber; Georgetown University School of Medicine, 1934; age 61; died June 30, 1969. He was a radiologist at Memorial Hospital, Johnstown. No survivors are listed.

○ **Francis R. Wise,** York; College of Physicians and Surgeons, Baltimore, Md., 1908; age 81; died July 5, 1969. He was a fellow of the American College of Physicians, was a recipient of the PMS award for fifty years of service to the medical profession, and in 1959 was named "general practitioner of the year" by the York County Medical Society. He is survived by a son and two daughters.

Peter Flesch, Philadelphia; Orvosi Tudomanyegytem, Budapest, Hungary, 1939; age 53; died July 1, 1969. Surviving are his wife and a sister.

George G. Grazier, Hollsopple; University of Maryland Medical School, 1914; age 82; died June 10, 1969. Surviving are his wife and a son.

Raymond C. Moyer, Lansdale; Hahnemann Medical College, 1932; age 62; died July 15, 1969. He is survived by his wife, two sons and a sister.

○ **Wendell J. Stainsby,** Danville; McGill University Faculty of Medicine, Montreal, Canada; age 71; died July 9, 1969. He had been director of the department of internal medicine at Geisinger Medical Center, and was named emeritus director in 1958. He is survived by his wife, a daughter, and a son, Wendell W. Stainsby, M.D., Gainesville, Fla.

SEPTEMBER

American Association of Obstetricians and Gynecologists, September 4-6, 1969, Hot Springs, Va.

American Society of Clinical Pathologists, September 14-21, 1969, Chicago, Ill.

Congress on Occupational Health, American Medical Association, September 15-16, 1969, St. Louis, Mo.

Pennsylvania Society of Colon and Rectal Surgery, 2 to 5 p. m., Wednesday, September 17, 1969, Host Farm Motel, Lancaster, Pa.

American Academy of General Practice, September 26-October 3, 1969, Philadelphia, Pa.

PMS Scientific Sessions, September 15-18, 1969, Host Farm Motel, Lancaster, Pa.

Fourteenth International Symposium on Leukemia Research, Leukemia Society of America and National Cancer Institute, September 21-25, 1969, Cherry Hill, N. J.

OCTOBER

Annual Otolaryngologic Assembly of the University of Illinois College of Medicine, October 4-10, 1969, at the Illinois Eye and Ear Infirmary, Chicago, Ill. Contact Otolaryngology, P. O. Box 6998, Chicago, Ill. 60680.

American College of Surgeons Clinical Conference, October 6-10, 1969, San Francisco, Calif.

PMS Annual Business Session, October 8-12, 1969, Marriott Motor Hotel, Philadelphia, Pa.

PMS Woman's Auxiliary, October 8-12, 1969, Marriott Motor Hotel, Philadelphia, Pa.

American Academy of Ophthalmology and Otolaryngology, October 12-17, 1969, Chicago, Ill.

Conference on Old Age, Philadelphia Geriatric Center and Stephan Smith Home for the Aged, Monday, October 13, 1969, York House South, 5325 Old York Rd., Philadelphia.

Industrial Hygiene Foundation Annual Meeting, October 14-15, 1969, Chatham Center, Pittsburgh, Pa. Contact Robert T. deTreville, M.D., President, Industrial Hygiene Foundation, 5231 Centre Ave., Pittsburgh, Pa. 15232.

American College of Obstetricians and Gynecologists District Three Meeting, October 16-18, 1969, Pittsburgh Hilton Hotel, Pittsburgh, Pa.

Fourteenth Annual Conference of the Committee on Nutrition and Metabolism of the Philadelphia County Medical Society, October 22, 1969, Auditorium, Temple University Medical Center.

American Society of Anesthesiologists Annual Meeting, October 25-29, 1969, Hilton Hotel, San Francisco, Calif.

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(2) **FAMILY THERAPY**
Salvador Minuchin, M.D.; Charles A. Malone, M.D.; Jay Haley

(3) **BEHAVIOR THERAPY**
John Paul Brady, M.D.; Aaron T. Beck, M.D.; Joseph Wolpe, M.D.; Arnold A. Lazarus, Ph.D.

SPRING COURSES:

(4) **MARITAL THERAPY**
Harold I. Lief, M.D.; David M. Reed, Ph.D.; Donald R. Young, Ed.D.

(5) **PSYCHOPHARMACOLOGY**
Karl Rickels, M.D.; Myer Mendelson, M.D.; William L. Webb, Jr., M.D.; Joe Mendels, M.D.

Enrollment is limited to psychiatrists. The deadline for registration for Fall courses is September 15. Registration deadline for Spring courses is January 30, 1970. There is a tuition fee of $50.00. All classes will meet at the Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia, with the exception of the Family Therapy course which will meet at the Philadelphia Child Guidance Clinic. Interested psychiatrists should contact Gerald J. Margolis, M.D., The Institute of the Pennsylvania Hospital, 111 N. 49th St., Philadelphia, Penna. 19139.

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PENNSYLVANIA MEDICINE

in my opinion

Hospital Libraries

The hospital always has had a dual function. Primarily for patient care, hospitals at the same time have served as centers for medical learning. Within recent times the latter function has assumed increasing emphasis and the director of medical education of the hospital has become an important leader of the hospital staff. Usually his activities are concentrated around the conference room and the patient's bedside. In the past, knowledge was based upon the teachings of our predecessors with new ideas and methods cautiously added from time to time only after careful searching and deliberations at scientific meetings. With the advent of radio and television, suddenly the public has become a partner in these discussions. Impatient with the traditional skepticism of doctors, there is a strident clamor against any gap between the time new knowledge is generated and the time it is applied by physicians to the benefit of patients. Reflecting such public concern, this gap has worried Congress, where members feared doctors may not be "up" on the latest information. As pointed out by one of our most knowledgeable professional librarians, Scott Adams, deputy director, National Library of Medicine, "There is a healthy and lively ferment, with general agreement on new goals, but little consensus on the ways" to reach doctors in order to convey new knowledge rapidly.

Since the reform of medical education that followed the Flexner Report in 1910, medical schools have achieved great success in starting the doctor in practice at a high level of skill and efficiency. One problem now is how to keep the busy practitioner on his lonely rounds abreast of continuing improvements after graduation. This is where the hospital library can come in as the proper center for medical learning. Here, a new class of medical assistants is developing in the form of medical librarians. To the existing core of books and journals, the library can add new methods and equipment for information dissemination. Audio-visual materials, closed circuit television and other innovations are available. Soon electronic networks will add facilities to transmit needed knowledge at computer speeds. All these make the medical librarian an important member of the health team.

Samuel X. Radbill, M.D.
Reprinted from
Philadelphia Medicine

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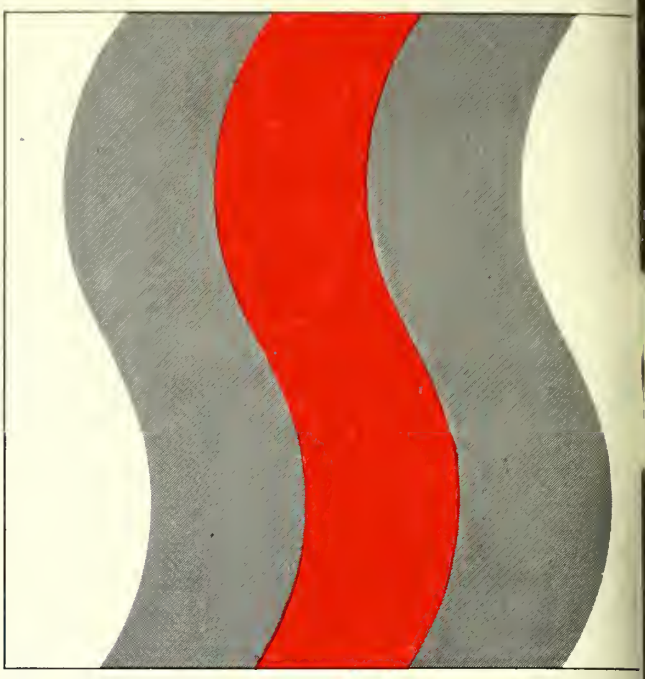

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

PENNSYLVANIA MEDICINE

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OCTOBER 1969

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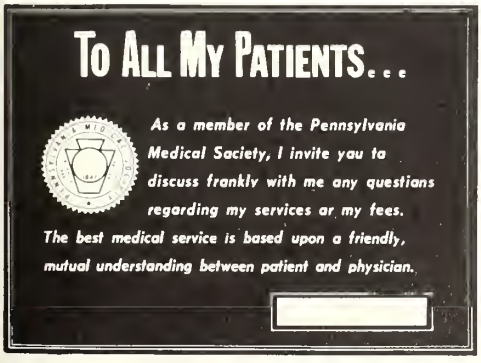
OCTOBER, 1969

PMS 1969 SCIENTIFIC SEMINAR REGISTERS OVER A THOUSAND

Over a thousand physicians, nurses, visitors and program speakers were at Host Farm Resort Motel, Lancaster, September 15-18 attending the Pennsylvania Medical Society's Scientific Seminar. A total of seventeen specialty societies in the state planned meetings to interest those specializing in that specific field, while all attended the general sessions, held each morning, dealing with new drugs and their most effective use against disease. A special seminar for nurses and allied professionals and a round table discussion of the PMS role in continuing education were part of the four-day session as well. Physicians attending the seminar received an hour's AAGP credit for each hour of attendance. John H. Killough, M.D., Ph.D., Philadelphia, associate dean of Jefferson Medical College, said that the patient is the person who ultimately benefits from such postgraduate medical education. Medical teachers, brought in from throughout the country, included: Jack L. Strominger, M.D., Boston, Mass.; Harry F. Dowling, M.D., Chicago, Ill.; Edward W. Hook, M.D., Cornell Medical Center; Henry Zimmerman, M.D., Cleveland, O. and Robert H. Peter, M.D., Durham, N.C. A picture story of the Scientific Seminar appears on pages 9 and 10 of this issue.

PENNSYLVANIA DOCTOR INSTALLED AS PRESIDENT OF AAGP

Edward J. Kowalewski, M.D., Akron, Pa. became the president last month of the second largest medical organizatio in the nation, the American Association of General Practitioners, at its convention in Philadelphia. The Lancaster County physician has served the AAGP in a number of capacities, and is a past president of the Pennsylvania Academy of General Practice. He served as president of the Lancaster County Medical Society in 1964.



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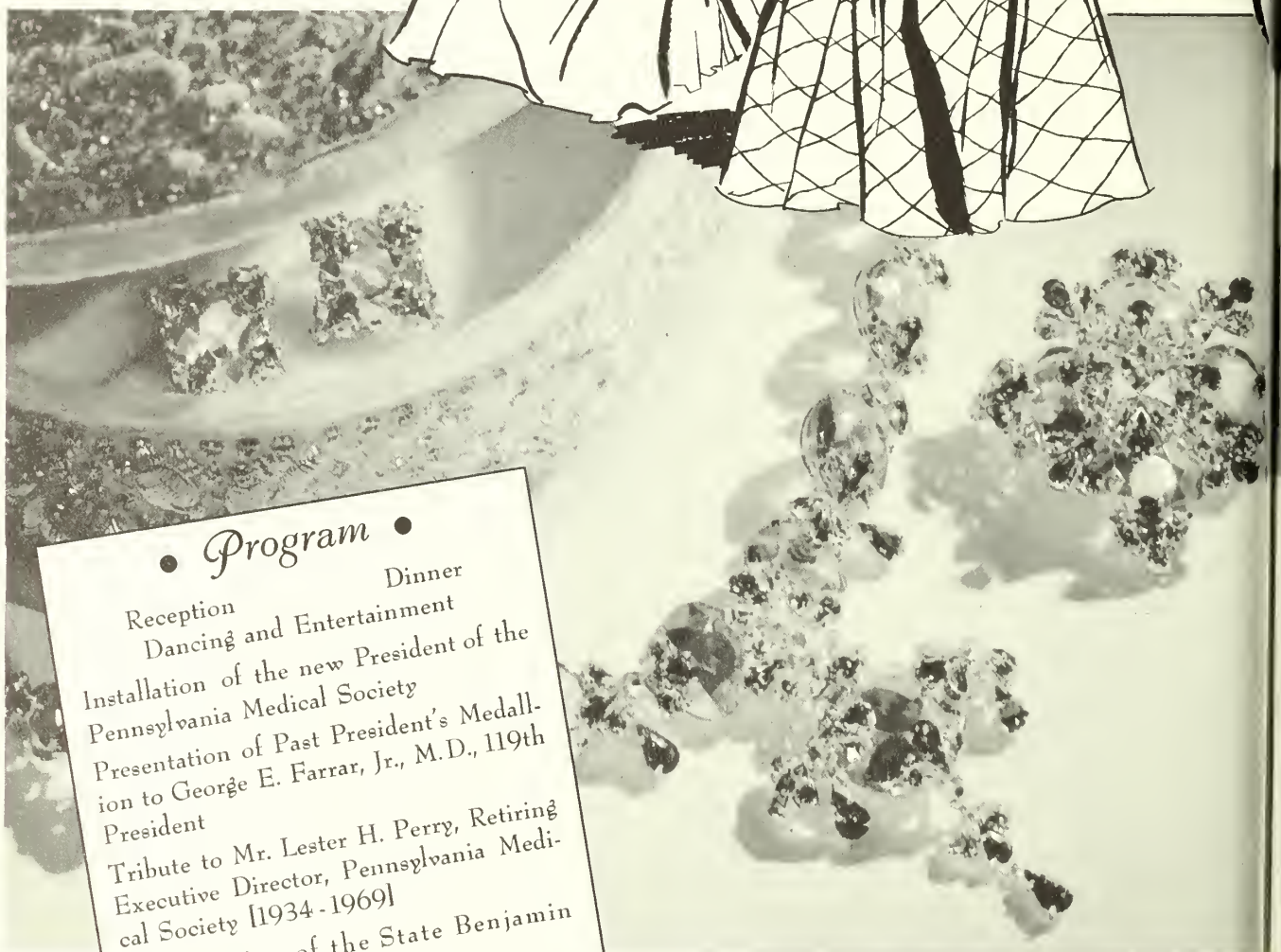
22nd Annual

STATE DINNER

FRIDAY EVENING
OCTOBER 10, 1969



Program

Reception
Dinner
Dancing and Entertainment
Installation of the new President of the Pennsylvania Medical Society
Presentation of Past President's Medallion to George E. Farrar, Jr., M.D., 119th President
Tribute to Mr. Lester H. Perry, Retiring Executive Director, Pennsylvania Medical Society [1934-1969]
Presentation of the State Benjamin Rush Awards

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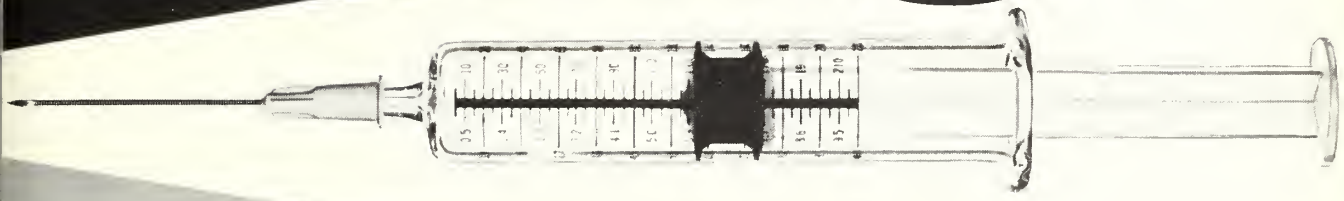

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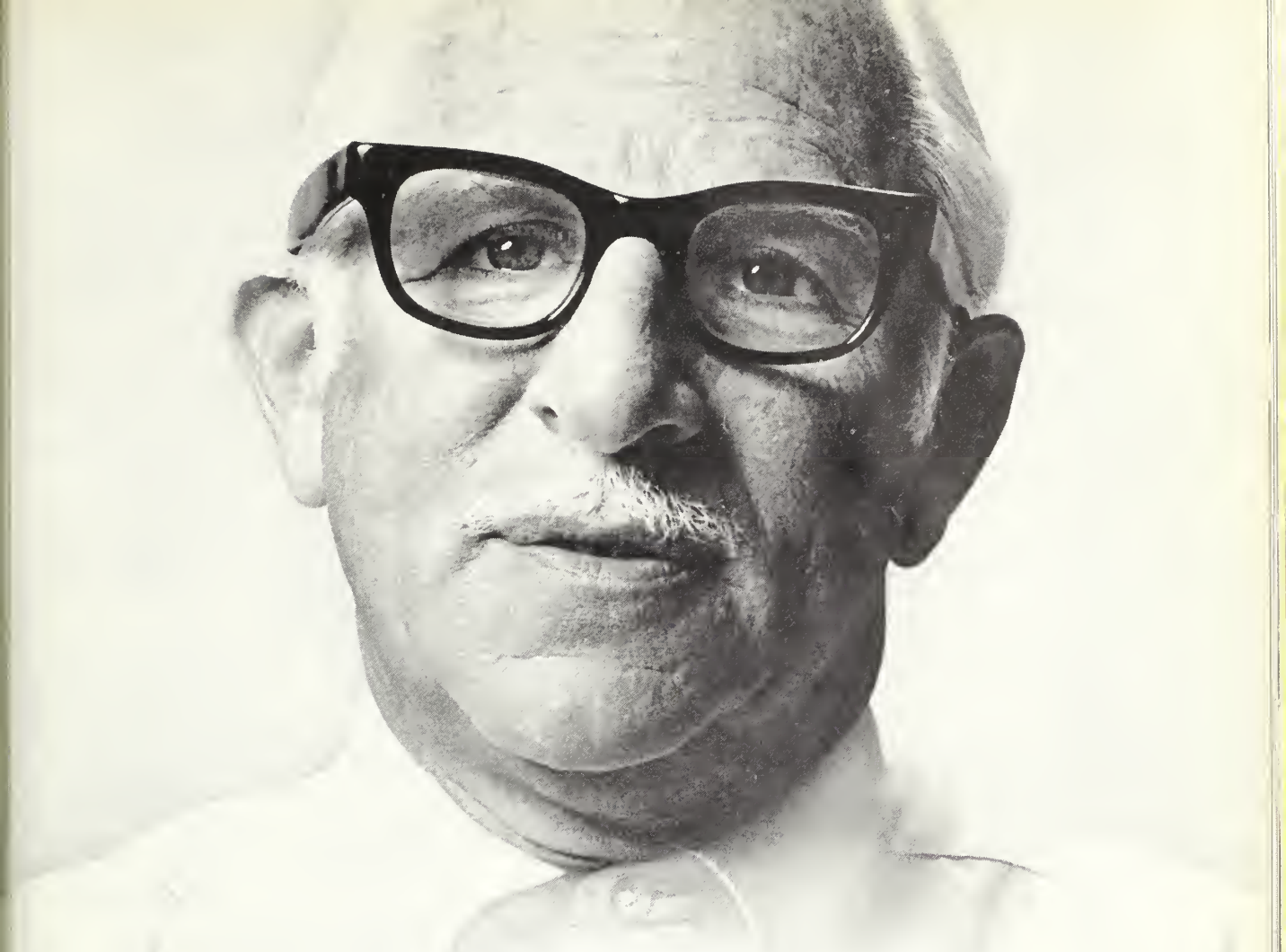

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fectiveness: Because its antibacterial component is DECLOMYCIN emethylchlortetracyeline, DECLOSTATIN should be equally or more fective therapeutically than other tetraeyelines in infections caused by tracycline-sensitive organisms. The antifungal component, Nystatin, otects against superinfection by antibiotic-resistant fungal overgrowth artieularly monilia) in the intestinal tract.

ntraindieation: History of hypersensitivity to demethylchlortetracy-ne or nystatin.

arning: In renal impairment, usual doses may lead to excessive accum-ation and liver toxieity. Under such conditions, lower than usual doses e indicated, and, if therapy is prolonged, serum level determinations ay be advisable. A photodynamic reaction to natural or artifieial sun-ght has been observed. Small amounts of drug and short exposure may oduce an exaggerated sunburn reaction whieh may range from ery-ema to severe skin manifestations. In a smaller proportion, photo-lergic reaetions have been reported. Patients should avoid direet posure to sunlight and diseontinue drug at the first evidenee of skin scomfort. Neeessary subsequent courses of treatment with tetracy-nes should be carefully observed.

Preeautions: Overgrowth of nonsusceptible organisms may oecur. Constant observation is essential. If new infeetions appear, appropriate measures should be taken. In infants, inereased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reaetions—urtiearia, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable ealcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the eoncomitant administration of high calcium content drugs, foods and some dairy produets. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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THE BREAKUP of a business partnership, the crack-up of a marriage, the shake-up of being fired or reduced to bankruptcy... after any significant loss or severe blow to self-esteem, *both* anxiety and depression almost always follow.

FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.

FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed,as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

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PENNSYLVANIA MEDICINE

newsfronts

Jeff, Mercy Cooperate in Academic Studies

An academic program for the medical education and training of Jefferson Medical College students at the Fitzgerald Mercy and Misericordia Divisions of the Mercy Catholic Medical Center was announced jointly by Sister Mary Michael, president of the medical center, and Peter A. Herbut, M.D., president of Thomas Jefferson University.

Under terms of the affiliation agreement, the two institutions will establish and conduct at the Fitzgerald Mercy and Misericordia Divisions, a cooperative academic program initially in the departments of medicine, surgery, obstetrics/gynecology and pediatrics. It is expected that this program for medical students will be enlarged to include other departments.

The affiliation will not affect the corporate setup of Jefferson or the 800-bed Mercy Catholic Medical Center. Each will continue to conduct its business and affairs under the control of its own officers and board.

Sister Mary Michael, president of the medical center, said "the treatment and welfare of patients in the four departments involved in the academic program will continue to be the responsibility of the Mercy Catholic Medical Center and will remain subject to the direction and control of the medical center and the members of its hospital staff on duty in those departments.

"Generally speaking," she explained, "we feel that this primary affiliation with Jefferson which shares our goals of quality patient care, education, research and community service, will contribute substantially to the center's program of continuing to improve the excellence of its medical services to its patients and to the community."

Dr. Herbut, president of Thomas Jefferson University, said "this is another example of Jefferson's continuous effort to cooperate with first-rate institutions in Philadelphia to conserve manpower, facilities and money. We are delighted to be associated with the Mercy Catholic Medical Center."

As part of the affiliation arrangement, Jefferson will collaborate with the coordinator of the Medical Center's academic program in providing guidance for the establishment, development and operation of all phases of professional education. In addition, Jefferson will assign medical students to the Mercy Catholic Medical Center to further their clinical experience.

Signing Affiliation *agreement with Jefferson Medical College for a new academic program for medical education and training of Jefferson students at the Fitzgerald Mercy and Misericordia Divisions of the Mercy Catholic Medical Center are Mother Mary Bernard (seated), chairman of the board of the Medical Center, and Peter A. Herbut, M.D., president of Thomas Jefferson University. Also participating in the ceremony are (standing, left to right): Joseph A. Hesch, M.D., medical director for the Center; Ward D. O'Sullivan, M.D., coordinator of the academic program; Sister Mary Michael, president of the Medical Center; Francis J. Sweeney Jr., M.D., director of Thomas Jefferson University Hospital; and William F. Kellow, M.D., dean of Jefferson Medical College.*

PMS Board to Study Specialty Committee

The PMS Board of Trustees has appointed a special committee to make specific recommendations at the next board meeting concerning the possible establishment of a committee of specialty society representatives within the framework of the State Society.

In addition, the Board voted to forward, without comment, to the House of Delegates a resolution urging that established state specialty organizations be represented by voting delegates in the House of Delegates for a trial period of two years.

PMS Roundup Education & Scientific Trust

■ The education arm of the state's medical doctors today announced that $172,039 in aid was provided to 224 Pennsylvania students during the last school term. It is pocketbook-deep in additional commitments for the coming year as part of its continuing concern over the health manpower shortage.

The announcement was made by the chairmen of the PMS Educational and Scientific Trust, James Z. Appel, M.D., of Lancaster. In the previous year, Trust aid totaled $141,852.

Of the aid provided, $152,899 was in scholarships and loans for 153 medical students from the state and the other $19,140 in trust funds went to seventy-one state students in the paramedical field.

Of the 1968-69 funds allocated to medical students by the trust, $44,099 was in non-repayable scholarships and $108,800 in loans, which are interest free until medical practice begins. Repayment of loans then provides funds for financial aid to other students.

Dr. Appel lauded his fellow physicians in Pennsylvania whose support through dues and gifts made the educational support possible. "The 12,000 physician-members of the Pennsylvania Medical Society are aware of the need to insure an adequate supply of physicians and other health team members for future generations. The Trust reflects their concern and indicates their willingness to assist medical personnel of tomorrow."

Commenting on the current financial crisis facing many medical students, Dr. Appel said he hopes no qualified student wlil be denied a medical education because of lack of funds. "The need for additional health team members is too great," he said.

Dr. Appel added that the trust is continually enlarging and improving its aid programs to meet increasing medical student demands brought on by the rising cost of medical education, the shortage of federal funding and higher loan interest rates. The federal cuts have come at the same time that the federal government and others are screaming about a medical personnel shortage.

In addition to direct physician funds, the trust administers a number of programs established by county medical societies and others. Trust offices are in the PMS headquarters in Lemoyne, Pa.

Pennsylvania Medical Society Educational and Scientific Trust
Students Receiving Loans and Scholarships
1968-69 School Year

County	*No. Students*	*Amount*
Adams	1	$ 600.00
Allegheny	16	12,195.00
Beaver	7	3,750.00
Berks	2	2,250.00
Bucks	2	3,200.00
Butler	1	550.00
Cambria	4	3,550.00
Columbia	2	1,750.00
Cumberland	2	2,950.00
Dauphin	10	5,395.00
Delaware	9	10,815.00
Elk-Cameron	1	1,000.00
Erie	26	9,170.00
Fayette	1	1,700.00
Franklin	2	2,000.00
Jefferson	1	1,000.00
Lackawanna	4	4,125.00
Lancaster	5	6,677.00
Lawrence	2	2,300.00
Lehigh	30	9,480.00
Luzerne	13	11,747.00
Lycoming	2	1,750.00
Mercer	4	4,900.00
Mifflin-Juniata	1	1,500.00
Montgomery	8	8,020.00
Northampton	1	1,000.00
Northumberland	2	1,850.00
Philadelphia	42	41,990.00
Schuylkill	4	2,050.00
Venango	1	500.00
Washington	10	6,500.00
Wayne-Pike	1	1,000.00
Westmoreland	5	3,425.00
York	2	1,350.00
	224	$172,039.00

"Truth in Lending" Reminder to M.D.'s

Some physicians are affected by the Federal "Truth in Lending" Act which became effective July 1 of this year.

Although the bill is designed primarily for lending institutions and installment purchases, it was pointed out that it applies to any physician who agrees to be paid for his medical services in more than four installments even though there is no financial charge.

AMA attorneys outlined a suggested procedure for physicians in an article that appeared in the June 30 issue of the *AMA News*. Copies of that article are available free from the State Society.

Doctors R. C. Grandon, Harrisburg; R. H. Smith, Downingtown; and W. A. Limberger, West Chester, in a shop-talk break.

Joseph M. Garfunkel, M.D., Harrisburg, speaks on "The Medical Attendant As A Vector In Infections"

Pictorial Scrapbook

PENNSYLVANIA MEDICAL SOCIETY

1969 Scientific Session

HOST FARM RESORT MOTEL, LANCASTER
SEPTEMBER 15-18, 1969

One of four round table discussions on "The Role Of The Pennsylvania Medical Society In Education"

"Antibiotics, Bacteria and the Host" is program feature of the PMS Seminar morning session.

PMS 1969 SCIENTIFIC SESSION

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effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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Mild ulcerative colitis may be triggered here...

In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CI depressants. As with all CNS-acting drugs, ca tion patients against hazardous occupations quiring complete mental alertness (*e.g.*, operati machinery, driving). Though physical and p chological dependence have rarely been report on recommended doses, use caution in a ministering Librium (chlordiazepoxide hydr chloride) to known addiction-prone individu or those who might increase dosage; withdraw symptoms (including convulsions), follow discontinuation of the drug and similar to tho seen with barbiturates, have been reported. U of any drug in pregnancy, lactation, or in wom of childbearing age requires that its potent benefits be weighed against its possible hazar As with all anticholinergic drugs, an inhibit effect on lactation may occur.

PRECAUTIONS: In elderly and debilita limit dosage to smallest effective amount to p clude development of ataxia, oversedation confusion (not more than two capsules per d initially; increase gradually as needed and tol

or here.

). Though generally not recommended, if combination therapy with other psychotropics is indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychotic patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

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BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

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newsfronts

AMA Clears Track for D.O. Membership

With the final decision up to each individual state, the American Medical Association House of Delegates has cleared the way for doctors of osteopathy to become active members of the AMA. AMA membership is limited to regular members of state societies.

The PMS House of Delegates, at the 120th Annual Session this month, will be considering changes in the State Society constitution and bylaws to allow membership by *qualified osteopaths*.

Because State Society members must be members of a county society, affirmative action by county medical societies also would be required before an osteopath could attain to the three levels of medical society structure.

Civil Defense Contribution

Laurie J. Cromier, *left, director of the Office of Civilian Defense Region I, presented a distinguished service citation to Francis C. Jackson, M.D., right, for his contributions to the nation's civilian defense posture while serving on the AMA Committee on Disaster Medical Care at the recent AMA Convention in New York City. The presentation was made at a session on aircraft disasters.*

SVRMP Emphysema Program To Be Studied

Doctors, nurses, hospital administrators and other health workers from an eleven-county area of southcentral Pennsylvania have expressed their approval of two projects designed to improve the health care of the area's citizens.

At its meeting recently in Harrisburg, members of the Susquehanna Valley Regional Medical Program's Southern Area Committee approved an emphysema program submitted by Community General Osteopathic Hospital, Harrisburg, and the expansion of a training program for inhalation therapists at St. Joseph Hospital, Lancaster.

The regional medical program, which brings into cooperative arrangement the health resources of a twenty-seven county portion of central Pennsylvania, has as its goal the improvement of patient care in the areas of heart disease, cancer, stroke, and related diseases.

The emphysema project provides that space would be allocated in the new Community General Osteopathic Hospital for an emphysema treatment center. Treatment would involve a multi-disciplinary approach through the use of specially-trained personnel and special equipment in the areas of chemotherapy, physiotherapy and psychotherapy.

The inhalation therapy project provides for expansion of the capabilities of the St. Joseph Hospital School of Inhalation Therapy from its present eight-student class to twenty-four students.

The two projects now will be studied for their scientific merit by the SVRMP's Council on Heart Disease before being considered by the regional advisory group for a final decision as to whether the project should be submitted to the federal level for approval and funding.

Also at Thursday's meeting, the committee elected the following persons as representatives of the southern area to the regional advisory group:

Raymond C. Grandon, M.D., and Claude E. Nichols, M.D., both of Harrisburg; J. Frank Gayman, Chambersburg; Raymond Treon, Ph.D., Millersville; Robert Kumpf, Lewistown; and Charles E. Schlager, M.D., York.

Edgar W. Meiser, M.D., Lancaster, committee vice chairman, reviewed the progress of the southern area to date and presented nominees for membership on the area's five subcommittees—heart disease, cancer, stroke, continuing education and rural problems. All nominees were appointed.

Richard B. McKenzie, SVRMP program director, presented a report on the progress of the SVRMP and of regional medical programs on a national level.

The meeting also provided the opportunity for the health professionals and volunteers to discuss new ideas on how SVRMP can contribute more effectively to improving patient care in the southern area, according to Judge Clinton R. Weidner, of Cumberland County, who serves as Chairman of the Area Committee.

RMP Grant Awarded for Western Pa. Projects

A one-year grant of $1,157,896 has been awarded to the Western Pennsylvania Regional Medical Program to support five new health care projects and planning activities. A similar level of financial support has been approved for two additional years. According to Francis S. Cheever, M.D., coordinator for the program and vice chancellor for the Schools of the Health Professions, University of Pittsburgh, "This high level of funding during a time of tightly restricted federal spending indicates the success of health professionals in western Pennsylvania in soundly planning locally developed solutions to some of our health care problems."

These funds mark the beginning of the Western Pennsylvania Regional Medical Program's operational phase following over two years of planning. The projects are designed to promote cooperation among the Region's medical institutions and health professionals to further the fight against heart disease, cancer, stroke and four related diseases: emphysema, kidney disease, diabetes and hypertension. The grant is from the Regional Medical Programs Service of the Health Services and Mental Health Administration of the U. S. Department of Health, Education and Welfare, Bethesda, Maryland.

The funded projects include a wide range of activities:

- The development of a regional medical faculty designed to bring the latest in medical information to the practicing physician. The program would include lectures, teaching clinics, personal consultation and other medical teaching methods at some twenty hospitals in the Johnstown area.
- A program created to deal with the problems associated with hypertension. At monthly teaching clinics in nine hospitals from Altoona to New Castle, both an approach for treating a group of patients with hypertension and a critical evaluation of treatment methods will be taken, and new diagnostic tests will be made available in participating hospitals.
- A program to train 300 special nurses each year to staff modern hospital units for care of patients with heart attacks.
- A project designed to give ready access to medical information through a regional medical library system which will help community hospitals modernize their medical libraries and will provide latest information to the region's doctors and nurses.
- A program to bring administrators and nursing personnel in nursing homes the latest techniques for the care of patients with chronic diseases.

Funding for an additional project is anticipated within the year. This project will train teams in each of the region's 100 hospitals to bring back to life persons whose hearts have stopped.

"The significance of the program which these projects initiate," said Robert R. Carpenter, M.D., director of WPRMP "lies in the growing cooperative effort which they represent. Many of our busiest physicians, hospital administrators, hospital trustees and other health professionals have devoted long hours to make the program possible. This investment is clear testimony to their continuing determination to do everything possible to bring their patients the very best in health care. We believe that this coordinated, cooperative effort will speed the development of the latest medical advances to this region."

Unlike many federal programs, funds provided for RMP projects are not awarded to specific institutions, but to the region as a whole. Apportionment of funds is determined by the advisory committee of the Western Pennsylvania Regional Medical Program, which is comprised of some forty-five members, including physicians, nurses, hospital administrators, other health professionals and consumers. Specific institutions engaged in RMP projects receive funds by affiliating with the program.

A number of the projects are essentially pilot efforts in fairly restricted localities. Those which prove successful must be expanded throughout western Pennsylvania as the program grows. The projects currently involve active participation of twenty-five hospitals in nine counties in Western Pennsylvania. Many other hospitals will participate indirectly by providing students for the various training projects. Health leaders throughout the region have formed area planning groups to help develop these projects in other hospitals and to plan needed additional projects.

The western Pennsylvania program includes twenty-eight counties and is one of fifty-five Regional Medical Programs across the nation working to provide improved patient care for those suffering from heart disease, cancer, stroke, emphysema, diabetes, kidney disease, and high blood pressure. Approximately 70 per cent of all Americans will die from one of these conditions, and the Regional Medical Program is a concentrated effort to reduce these deaths.

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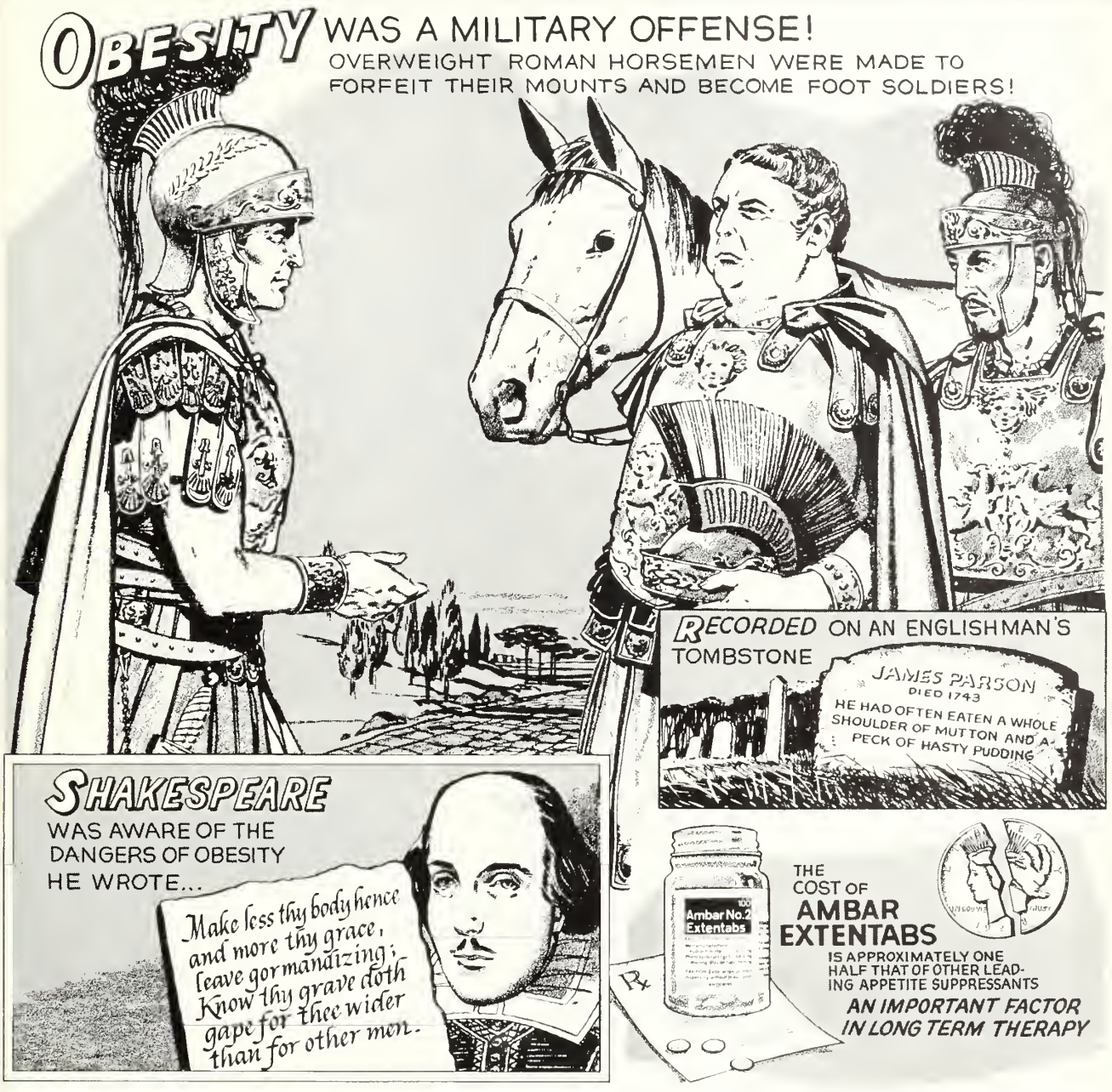


CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

Blue Shield Introduces Improved Check/Voucher Form

Pennsylvania Blue Shield began using an improved check and voucher form for all Blue Shield claim payments on September 1. The new check and voucher included all information which has been printed on the previous form, plus additional information for Prevailing Fee Program payments.

The new form, appearing here in reduced size, will be printed on paper rather than card stock as in the past. Computer printed information will continue to be listed on the voucher for the subscriber's enrollment area, agreement number, patient's name and relationship to the applicant, date of service, plan of coverage, claim number, service (procedure) code and amount paid.

Four new columns have been added for information about Prevailing Fee Program payments as follows:

The *Prevailing Fee Allowance* column will show amount determined in accordance with the criteria of usual, customary and reasonable.

The *Less Deductible* column will show any deductible amount that must be subtracted from the prevailing fee allowance to determine PBS payment.

In the third listing on the sample voucher, $25.00 appears in this column. The reason: the subscriber's Prevailing Fee Program master contract provides for this deductible on home and office visits.

The *Less Coinsurance* column will not be used at present. It will be used in the future when Prevailing Fee agreements are sold which provide that the subscriber pay a percentage of the prevailing fee.

The *Less Amount Exceeding Maximum* column will show any amount not payable by PBS because the subscriber's agreement specifies a maximum for the service performed.

In the fifth listing of the sample voucher, thirty-one days of inhospital mental care were provided as indicated by the last two digits of the service code. The subscriber's Prevailing Fee Program master contract provides for payment for a maximum of thirty days of such care. The $5.00 shown in this column is the amount of the doctor's charge exceeding the specified maximum for this benefit.

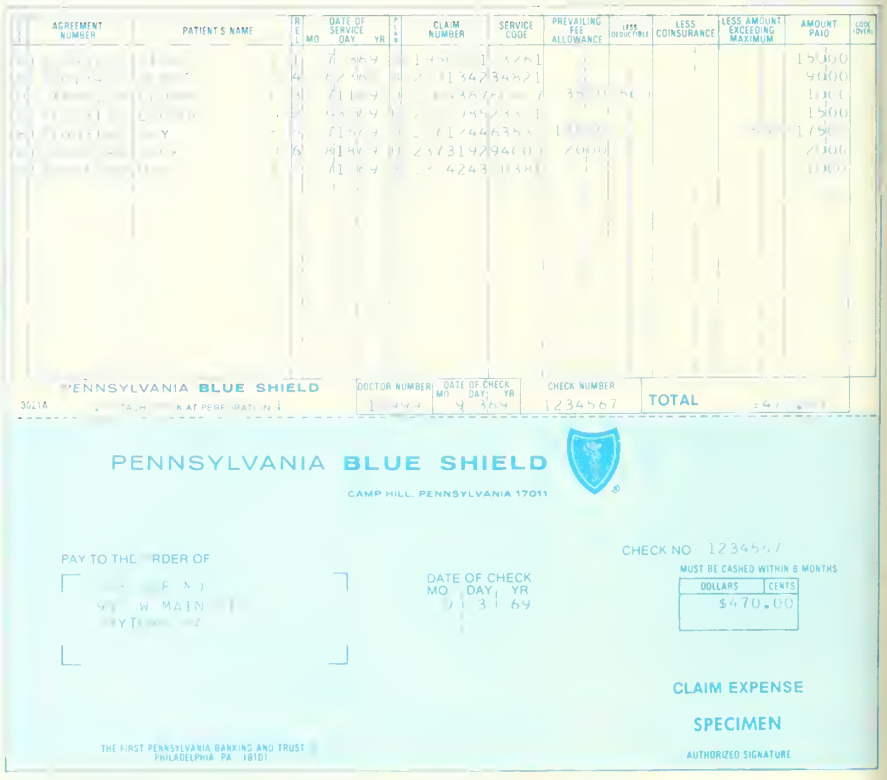
One new column, *Code,* has been added at the right for information about certain special payments. The code symbols which will be used in this column are explained on the back of the voucher.

The complete information about each claim payment listed on a check voucher will permit continued easy recording of as much of the information about each payment as a doctor wishes to keep in his records.

A message to the doctor receiving the payment check and voucher is printed on the back of the voucher. It explains in general terms the payment and what to do if there is a question about any payment.

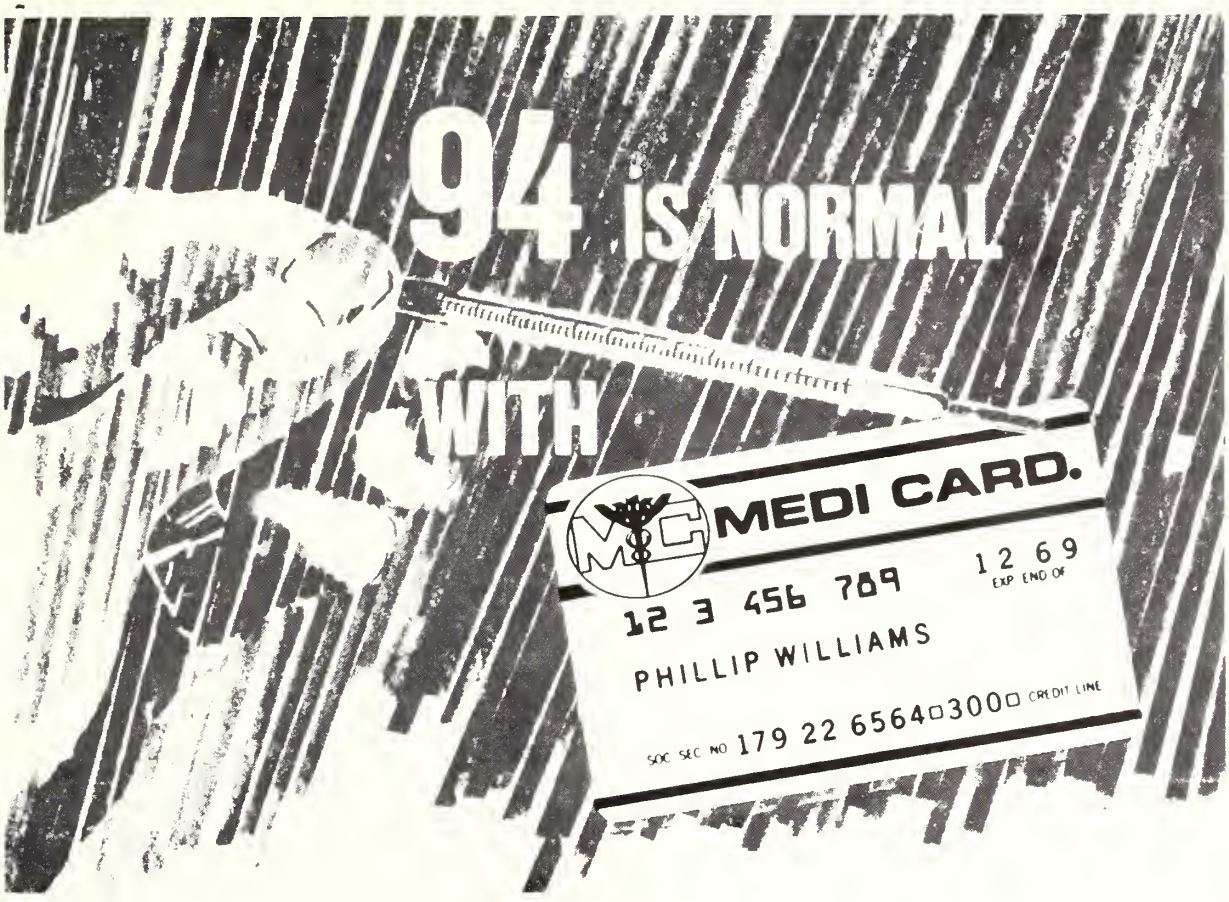
The explanation of code symbols mentioned above and explanations' of the terms *Prevailing Fee, Deductible, Coinsurance* and *Maximum* also are printed on the back of the voucher.

A "Notice of Claim Payment" will continue to be sent to the subscriber for each claim payment at the same time the check is sent to the participating doctor. It will include all the information which the doctor receives on the check voucher for each claim payment.



This is a reproduction of the new check and voucher to be used by PBS beginning September 1.

Take stock in America
Buy U.S. Savings Bonds & Freedom Shares



Yes! Medi Card guarantees you 94% payment within 10 days — without recourse.

This unique professional credit card exclusively for health services helps you get out of the credit and collection business . . . frees your capital for investment. You merely mail your draft to Medi Card on simple, easy-to-use forms supplied at no cost. Medi Card pays you promptly, less only a 6% service fee. There is no commitment on your part, nothing to join, no directory or listing of any kind. *Your patients benefit, in other ways, too!* Medi Card makes from $100 to $5000 available to patient-members exclusively for professional health services . . . lets them take up to 24 months to pay. As an additional benefit, Medi Card offers a round-the-clock computerized emergency medical information service for cardholders.

94 % IS NORMAL with Medi Card
Medi Card guarantees you payment within 10 days . . . without recourse.

EXCLUSIVELY FOR THE POST-PAYMENT OF THESE UNIVERSAL HEALTH SERVICES
☐ MEDICAL ☐ DENTAL ☐ HOSPITAL
☐ NURSING HOME ☐ PHARMACY
AND OTHER BONA FIDE HEALTH SERVICE CHARGES

MEDI CARD, INC.
P O Box 650
Bala Cynwyd, Pa 19004

Gentlemen I have not received my Medi Card kit. Please send one as soon as possible to

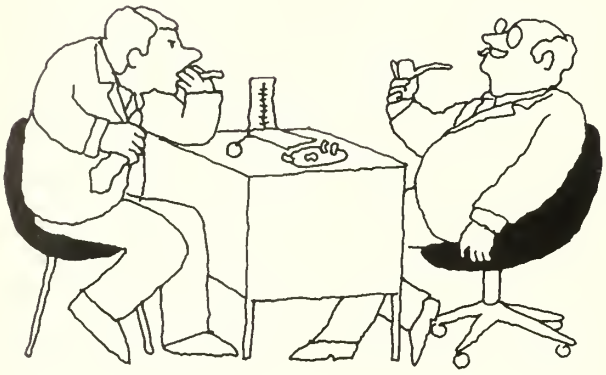
ATTENTION _____

ADDRESS _____

CITY _____ STATE _____

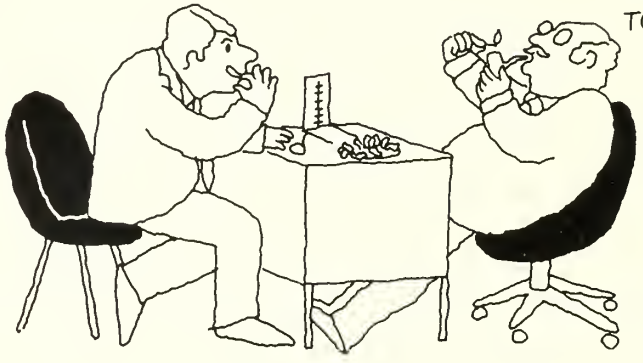
ZIP _____

The Apprehensive Hypertensive



WELL, YOU HAVE WHAT WE CALL MODERATE HYPERTENSION— HIGH BLOOD PRESSURE. NOW I DON'T WANT YOU TO WORRY, BUT WE ARE GOING TO HAVE TO CHANGE A FEW LIVING HABITS. FIRST, WE'RE GOING TO HAVE TO CUT OUT SMOKING—ALTOGETHER.

THEN WE HAVE TO LOSE WEIGHT. 20 POUNDS SHOULD DO IT... WE'LL TALK A LITTLE LATER ABOUT THIS DIET WE'RE GOING TO START.



Regroton® to lower blood pressure

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg. *Indications:* Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. *Precautions:* Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy the drug should be discontinued and potassium supplements given provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.

WE'VE GOT PROBLEMS.

and allay anxiety in hypertension

orticosteroids, ACTH, or digitalis. Severe salt restriction is not recom-ended. Use cautiously in patients with ulcerative colitis or gallstones biliary colic may be precipitated). Bronchial asthma may occur in usceptible patients. *Adverse Reactions:* The drug is generally well olerated. The most frequent side effects are nausea, gastric irritation, omiting, diarrhea, constipation, muscle cramps, headache, dizziness nd acute gout. Other potential side effects include angina pectoris, nxiety, depression, bradycardia and ectopic cardiac rhythms (espe-ially when used with digitalis), drowsiness, dull sensorium, hypergly-emia and glycosuria, hyperuricemia, lassitude, restlessness, transient yopia, impotence or dysuria, orthostatic hypotension which may be otentiated when chlorthalidone is combined with alcohol, barbiturates r narcotics, leukopenia, aplastic anemia, skin rashes, thrombocyto-enia, agranulocytosis, nasal stuffiness, increased gastric secretions, ightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic trophy and glaucoma, and pruritus. Eruptions and/or flushing of the kin, a reversible paralysis agitans-like syndrome, blurred vision, con-unctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms de-velop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dos-age:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

For details, please see complete prescribing information.

Regroton®
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

Jefferson Hosp. Offers Cost-saving Innovation

Thomas Jefferson University Hospital is now offering a new service that —for some patients—eliminates one of the biggest items in the hospital bill—the daily in-patient room and board charges.

The new service, unique in the Philadelphia area, is called the Short Procedure Unit. It is designed to handle treatments or short operative procedures that require no more than eight hours of time in the hospital for completion. This may include procedures requiring general anesthesia. The full range of hospital facilities will be available to patients registered in the unit, but they will not be official "in-patients" at the hospital. Plans were developed by Charles W. Semisch III, M.D., who is working with the entire staff to increase the effective use of Jefferson's facilities.

Many kinds of minor surgery and treatments are suitable for handling in the Short Procedure Unit, e.g. removal of skin cancers, D + C's, bronchoscopy, esophagoscopy, removal of fluid from chest or abdomen, transfusions of blood or special drugs, special surgical dental procedures. The two criteria for using the Special Procedure Unit are (1) the procedure is one best done in a hospital and (2) it can be completed within eight hours, with the patient recovered and ready for discharge.

If, for any reason, at the end of eight hours, the doctor decides that the patient must remain in the hospital, he can be quickly admitted as an in-patient and assigned to a regular hospital room.

How does the new system work? A reservation for the patient is made by his physician, preferably 24 hours in advance. He arrives at the hospital admissions area and laboratory tests are done first. He then goes to the Short Procedure Unit were he is prepared for the planned procedure, given necessary medication, etc. and taken to the operating room or treatment room. If general anesthesia is used, the patient goes from surgery to the Special Procedure Unit where he stays until ready to go home. On discharge, the patient must be accompanied by an adult relative or friend, as patients usually are when they go home from the hospital.

Patients in the Special Procedure Unit are charged the usual rates for use of the operating room, drugs and supplies, plus an hourly service charge while registered as a patient in the unit. There is no charge for room and board.

Jefferson has presented this plan to Blue Cross, Intercounty Hospitalization, and Medicare officials. All are willing to cover all services to these patients at the same level at which they would be covered if they were in-patients says Jefferson. Some private insurance companies have not yet come to a decision about their coverage, but Jefferson officials believe they will follow the pattern of Blue Cross.

About 5 per cent of patients up to now handled as in-patients in hospitals could be treated in the Short Procedure Unit, Dr. Semisch estimates. Projecting this estimate nationally, he pointed out that establishment of this type of unit would save patients and insurance companies about $133 million each year and free about 18,000 hospital beds.

COMPARATIVE BILLING: SHORT PROCEDURE VS. INPATIENT

D + C (Dilatation and Curettage)	**In-patient**	**Short Procedure Unit**
Room and board (admission PM day before surgery, discharge AM day after surgery)	$146.00	.....
Hourly service charge (Short Procedure Unit $5 per hour)	.....	$ 35.00
Laboratory tests and pathology	36.25	26.55
Operating room	70.00	70.00
Recovery room	25.00	25.00
Anesthesia	20.00	20.0
Drugs	5.40	5.40
Total	$302.65	$181.95
Excision of Nevus		
Room and board	146.00	.....
Hourly service charge SPU	.....	30.00
Laboratory tests	18.50	8.80
Operating room	50.00	50.00
Anesthesia supplies	10.00	10.00
Total	$224.50	$ 98.80

PMS House of Delegates to Meet

The PMS House of Delegates will conduct its regular elections as the first order of business at the Society's 120th Annual Session October 11, for the number of key positions to be filled.

The House will meet October 9-11 at the Marriott Motor Hotel, Philadelphia.

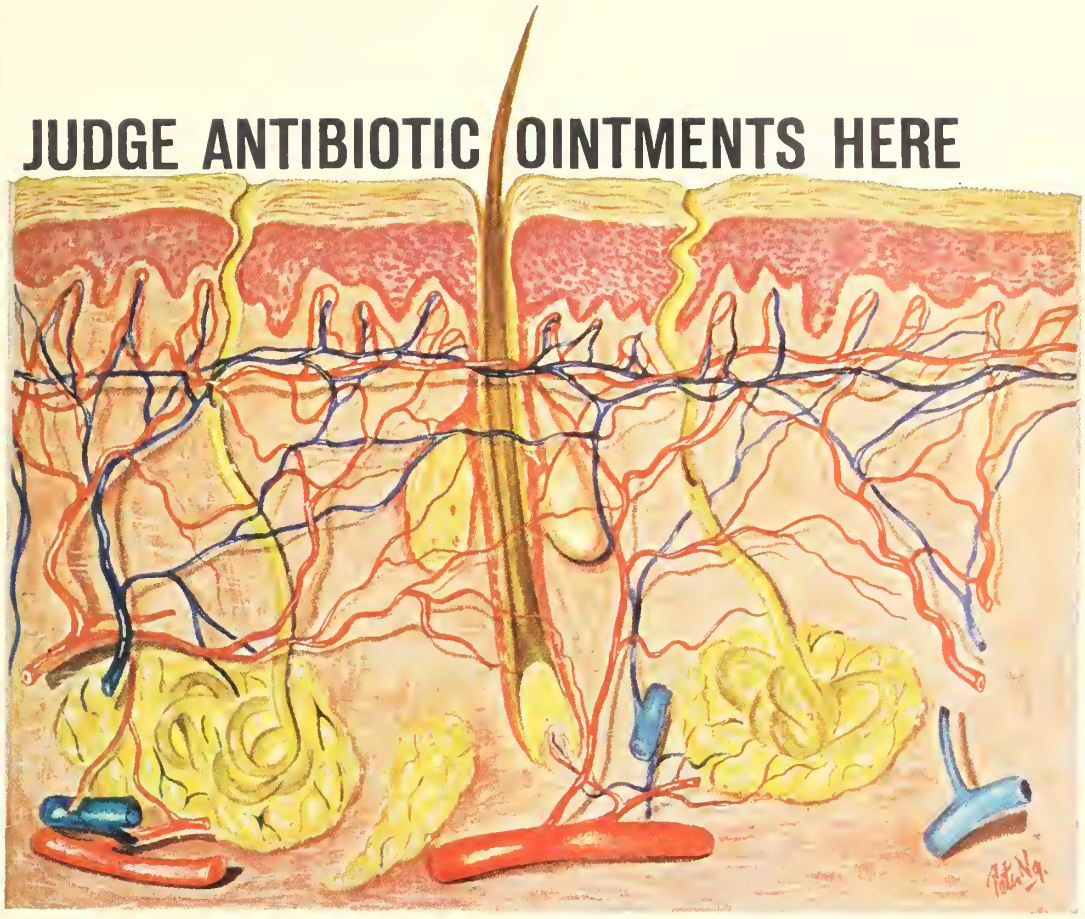
In addition to a president-elect and four vice presidents, offices to be filled will include that of secretary, speaker and vice speaker of the House of Delegates, a member of the Judicial Council, three positions on the Board of Trustees and Councilors, six delegates and six alternates to the AMA House, a position on the Committee to Nominate Delegates and Alternates, and district censors from each county society.

The incumbent secretary, Allen W. Cowley, M.D., Harrisburg, has notified the State Society that he will not be a candidate for reelection.

The terms of two members of the Board expire and both are eligible for reelection. They are A. Reynolds Crane, M.D., Philadelphia, and H. Thompson Dale, M.D., State College.

In addition, the Eighth District Trustee and Councilor, James A. Biggins, M.D., Sharpsville, has resigned effective at the October session, because of ill health and there will be an election to fill his term which expires in 1971.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

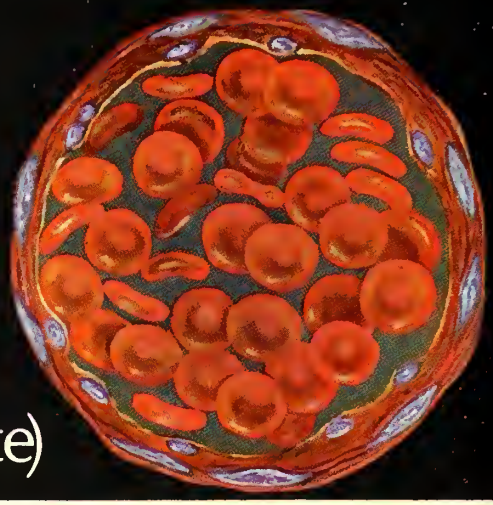
'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



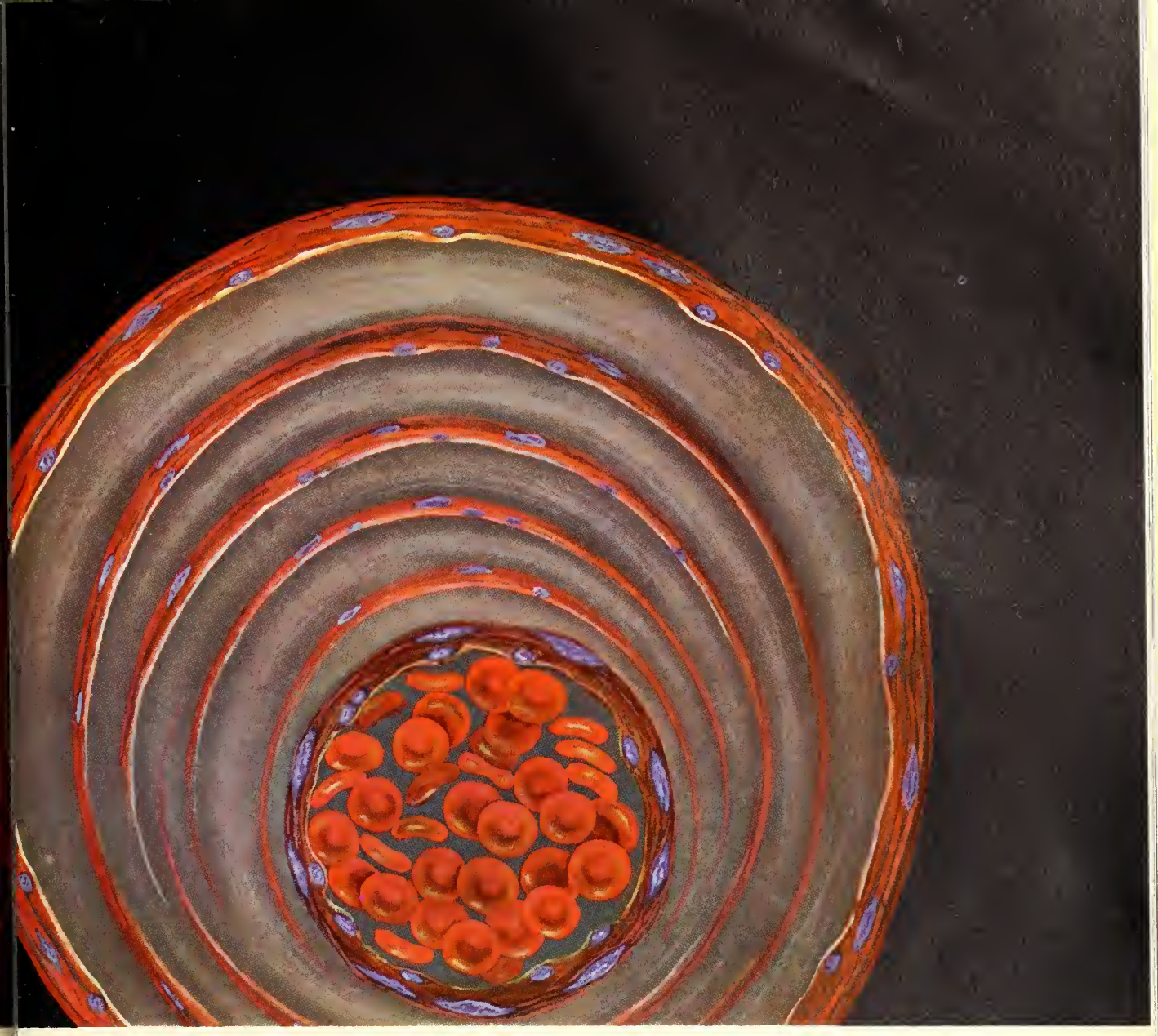
Because peripheral vasodilatio is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy.

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided f sustained-release Roniacol Timespan (nicot alcohol tartrate) Tablets. Part of the drug be comes available immediately, the remainde continuously over a period of up to 12 hour and dilation of constricted peripheral vesse usually maintained. Thus, with a single dose medication, patients can enjoy the benefits increased peripheral blood flow in ischemi extremities for up to 12 hours.



Smooth peripheral vasodilation from initial dosage...extended with simple, well-tolerated, b.i.d. dosage

...prolonged action of Roniacol Timespan ...ictinyl alcohol tartrate) together with its ...the benefits offer a therapeutically practical ...eature in the long-term management of ...eripheral vascular disease–advantages ...pecially important for older patients.

...efore prescribing, please consult complete ...roduct information, a summary of which ...llows:

...dications: Conditions associated with ...efficient circulation; e.g., peripheral vascular ...se, vascular spasm, varicose ulcers, ...ecubital ulcers, chilblains, Meniere's syn- ...ore and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

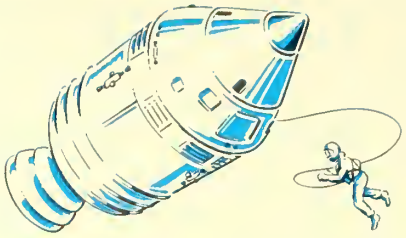
Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE

Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.



Mon in space, now foit occompli, re-emphasizes the importance of Uro-Phosphote therapy. Research into the effect of space trovel on the astronout reveals that weightlessness causes loss of bone calcium. As the bones ore required to bear less and less of the weight of the body they lose calcium, increosing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be odjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or blodder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each toblet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 toblets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicions and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals

HEW Reports on FDA Drug Findings

A three-year, intensive review of nearly 3,000 drugs that came on the market between 1938 and 1962 has resulted in a finding that 7 per cent are totally ineffective for all claims made on the label, according to an HEW news report appearing in a recent issue of *Consumer Newsletter.*

Action has been initiated to remove several groups of these drugs from the market, says the report, and in addition, the labeling of about two-thirds of the drugs was found inadequate as a guide to prescribing or dispensing the medicine.

In line with its consumer protection authority, the Food and Drug Administration commissioned the National Academy of Sciences/National Research Council to conduct the study. The review was necessary, says HEW, because until the enactment of the 1962 Kefauver-Harris amendments to the Federal Food, Drug and Cosmetic Act of 1938, the only federal requirement for marketing drugs was that they be safe. The Kefauver-Harris amendment requires that drugs must also be effective in the treatment of the ailments for which they are intended.

Thirty panels of physicians and scientists worked on the efficacy study. Because many of the 2,824 drugs evaluated have a number of different dosage forms and sizes, the actual number of drug preparations studies was nearly 4,000. Ten thousand judgments on label claims were made by the reviewing panel.

Most of the drugs are available on prescription. About 15 per cent are sold over-the-counter. Together they comprised 80 per cent of the drugs used in modern medical therapy.

In addition to the 7 per cent found to be totally ineffective for what their labels claimed, according to the report, an unspecified number of others were declared "probably" effective, "possibly" effective, "effective but" (usually meaning they were no longer approved forms of treatment) and "ineffective as a fixed combination." However, a considerable number of the drugs reviewed were rated as effective for all claims made.

FDA is now translating the recommendations into regulatory actions. This means, says the report, that some drugs may be removed from the market; changes will be required on the labels of others.

News accounts concerning the medicines taken off the market have centered on the antibiotic combination drugs. This doesn't mean, says HEW, that the individual antibiotics are not effective, rather the fixed combinations are not medically sound.

Drug manufacturers affected by the review will be given an opportunity to present the case for their products at hearings. For those drugs which are ineffective, but for which safety is not an issue, FDA will not remove them from the market until any hearing are completed. However, the companies must include a disclosure of the Academy findings that the product is ineffective in all promotional materials.

Radiologists Open Washington Office

The American College of Radiology has opened a Washington office for permanent government liaison, J. Frank Walker, M.D., college president, announced.

Otha W. Linton, formerly director of public relations at the ACR headquarters in Chicago, heads the capital operation. Charles Honaker, formerly of the American Medical Association, replaces Linton in the public relations post.

The college office will be located in the Bethesda-Bradley Building in Chevy Chase, Md. The site is just northwest of the District of Columbia and convenient to the many government health agencies now located away from the center of Washington.

William K. Melton, present ACR director of education, will move his activities to Washington. He will share responsibility for staff support of the Commission on Education with Clifford P. Wells, who is also director of audio-visual services for the ACR in Chicago.

Linton and Melton will work primarily with agencies of the Department of Health, Education and Welfare, the Atomic Energy Commission and other federal agencies having responsibility for health and radiation matters.

AUTHORS URGED TO SEND ART

AUTHORS WHO SUBMIT SCIENTIFIC OR FEATURE MANUSCRIPTS TO THE EDITORS OF PENNSYLVANIA MEDICINE FOR CONSIDERATION OF PUBLICATION SHOULD MAKE EVERY EFFORT TO INCLUDE ILLUSTRATIONS WHENEVER POSSIBLE.

IN RECENT MONTHS, YOUR STATE MEDICAL JOURNAL HAS MADE A STRONG ENDEAVOR TO SUPPLEMENT ORIGINAL PAPERS AND ARTICLES WITH AS MANY ILLUSTRATIONS AS POSSIBLE—EITHER PHOTOGRAPHS OR ORIGINAL ARTS—IN ORDER TO BRING MORE INTEREST TO THE SUBJECT MATERIAL AND ENHANCE THE APPEARANCE OF THE PUBLICATION.

AUTHORS ARE ENCOURAGED TO FEEL FREE TO INCLUDE ANY FORM OF QAULITY ARTWORK OR PHOTOGRAPHS WITH THE PAPERS THEY SUBMIT, CONSIDERING A QUANTITY OF FIVE ILLUSTRATIONS AS MAXIMUM, IN ADDITION TO REQUIRED CHARTS, GRAPHS, AND TABLES.

Health Week Set for Oct. 19-26

The seventh annual observance of Community Health Week, established by the AMA House of Delegates in 1962, is slated for October 19-26 in most participating communities.

The national theme, "Teaming Up for Better Health," focuses attention on continuing advances in health care and medical science, the application of these advances in the community, and local health problems and needs.

Two timely themes, recruiting health manpower and emergency medical identification, are areas of concentration for the AMA in its promotion of the idea. Community Health Week is sponsored by the medical profession and the programs are coordinated through local medical societies.

newsfronts

Bradford, Susquehanna in Sigmoidoscopy Program

The Pennsylvania counties of Bradford and Susquehanna will be a part of a new project designed to teach physicians sigmoidoscopy, according to Richard H. Lyons, M.D., director of the Central New York Regional Medical Program.

Bradford and Susquehanna are part of fifteen counties in central New York and Pennsylvania covered by the Central New York Regional Medical Program.

Under this program, intensified courses in sigmoidoscopy will be offered to physicians throughout the region. Consultation for physicians in their own offices is also provided.

Seventy per cent of the new colon and rectal cancers found could have been visualized, diagnosed, treated and hopefully cured if early detection by sigmoidoscopy had been achieved during the routine annual physical examinations.

Dr. Lyons said, "It is essential that every doctor's office be a cancer detection center and that sigmoidoscopy become a part of all routine initial and periodic complete physical examinations on patients over forty years of age."

Medical Studies Slated on Erie Campus

Liberal arts colleges may have an important role to play in continuing medical education in the United States —especially in areas isolated from medical education centers.

This possibility will be explored by the Division of Physician Manpower, Bureau of Educational Manpower Training, NIH, under a one year, $38,990 contract with Gannon College, Erie.

Some 250 physicians and osteopaths in the Erie area have a desire to upgrade the quality and effectiveness of their continuing medical education. They are separated by distance and state boundaries from medical education centers. Members of the Erie County Medical Society and the Pennsylvania Osteopathic Association have sought the assistance of nearby Gannon College in bringing together various educational resources and in formulating and administering an effective, comprehensive and coordinated continuing education program for the physicians in the area.

Gannon College, a private, liberal arts college with an enrollment of 3,300, will make available its administration, faculty resources, educational organization experience, library and physical plant facilities under the proposed program. The college will coordinate activities of all the agencies and individuals who are engaged in conducting existing education programs, including the medical societies, the directors of medical education, and the hospitals in the Erie area. The college will also formulate relationships with medical education centers, the Regional Medical Program, and educational television networks to see that these institutions and programs are fully utilized in a continuing education program for the medical professions in Erie and Northwestern Pennsylvania areas.

There are many liberal arts colleges that exist in areas isolated from medical education centers. Dr. Frank W. McKee, director, division of physician manpower, said that "The experience of Gannon College could encourage and help many liberal arts colleges to enlarge their educational role by bringing together resources for the continuing education of the local medical community."

New Courses at Hahnemann

During the coming academic year, the department of psychiatry of Hahnemann Medical College and Hospital of Philadelphia will conduct two broad-based post-graduate education programs for physicians. One is directed to the more general needs of pediatrician, obstetrician-gynecologist and general practitioner. The other is planned specifically for psychiatrists. Both programs are under the direction of Paul Jay Fink, M.D., director of psychiatric education and associate professor of psychiatry.

While the main part of the post-graduate education program is held at Hahnemann, a series of programs are planned for non-psychiatric physicians in Cherry Hill, N.J., Lancaster, Pa., and Harrisburg, Pa.

Among the subjects to be covered in the lecture series to be held at Hahnemann for non-psychiatric physicians are: sexual problems in medical practice; psychology of medical practice; seminars in psychotherapy; psychiatric problems of children; and clinical seminars in child psychiatry.

Seminars for the psychiatrists include: politics and problems of community mental health; behavior therapy; basic psychology for psychiatrists; family process and family therapy; and advanced family therapy.

Drug Firm Releases Medical-legal Film

"NEXT WITNESS" is the name of a new film released by the William S. Merrell Company division of Richardson-Merrell, Inc. in cooperation with the American Medical Association and the American Bar Association.

Another in a series of Merrell's program of medical-legal topics, the motion picture deals with the subject of medical testimony and the preparation by both physician and attorney.

Running 24 minutes in 16 mm. color, the film is available as a free loan from: Film Library, The William S. Merrell Company, Division of Richardson-Merrell, Inc., 1269 Gest Street, Cincinnati, Ohio 45203.

Patient comfort is your concern.

Patient comfort in chronic constipation is enhanced by restoration of normal pattern of evacuation.

- ☐ Gentle neuroperistaltic stimulation is mediated through the Auerbach's plexus in the colon
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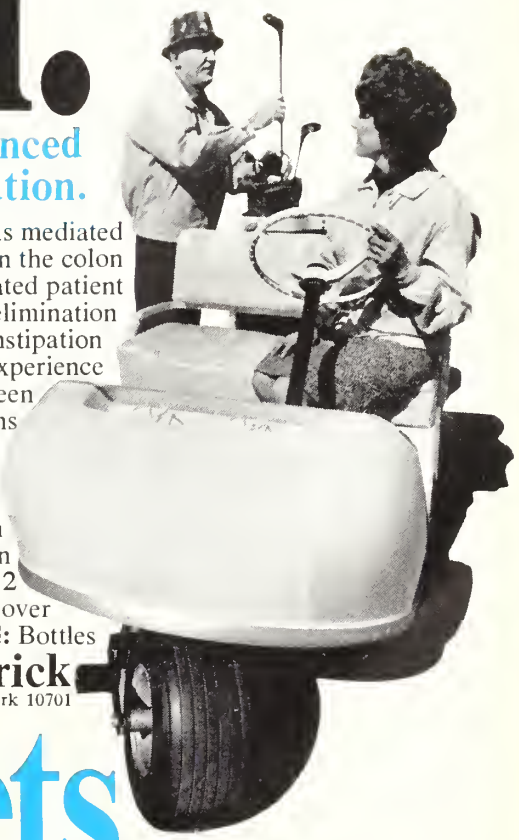

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Computers: A Malpractice Risk?

Increasing use of the computer for medical diagnosis and treatment could sharply raise the risk of malpractice by doctors and hospitals, a Cleveland attorney warned in a paper delivered at the annual convention of the American Bar Association.

"Although it will undoubtedly result in improvement in diagnosis, treatment and patient management, it will also raise new problems in the field of medical and hospital malpractice," said Philip J. Hermann.

Mr. Hermann's paper was presented at a meeting of the committee on general liability law and miscellaneous casualty insurance law of the ABA's section of insurance, negligence and compensation law.

With its wealth of medical data, the computer could set the accepted medical standard, Mr. Hermann noted, and failure by a doctor or hospital to utilize this information might constitute grounds for a malpractice action.

"It is anticipated that in areas where the computer could have cured, minimized or prevented medical problems, failure to employ the computer where it may have been indicated, whether it be diagnosis, treatment or patient management will enter into the question of whether current medical standards have been applied."

Initially, the possibility of malpractice will be greater at the hospital, according to Mr. Hermann, since the cost of the computer might limit its use by the private practitioner. However, once it is clearly demonstrated that the computer can lessen error in diagnosis and treatment it will attract the "conscientious" practitioner, he added.

"For the same reason, malpractice insurance carriers may also force the individual practitioner to cut down potential malpractice claims by requiring judicious use of the computer as a prerequisite to coverage or establish higher rates for those who do not enlist the aid of the computer," Mr. Hermann continued.

"Accordingly, it is foreseen that in fifteen or twenty years from now the individual physician's office may either be hooked up to a hospital or medical school computer center or his office may be in or close to a hospital or other institution offering computerized services. Hospitals in small cities will be connected by telephone to computers at large hospitals or medical schools. It is only a question of time until the average medical practitioner will be relying upon computers in the practice of medicine."

Mr. Hermann said malpractice suits might also stem from overestimating the capabilities of the computer. "It is foreseeable that the public, particularly jurors, may overestimate the capabilities of the computer," he said, "Likewise, the medical profession itself may do so. This may result in reliance on computers that is neither desirable nor practicable.

"The computer can be no better than the information contained in it, nor any better than its programming. Certainly at the present state of medical knowledge even if all available medical knowledge were computerized, the computer would be unable to effectively operate in many aspects because of the inconsistency involved. Certainly obsolete medical information or medical information not based upon the solid scientific foundation cannot be made better by being in a computer. Its application by the computer would only result in bad medical practice."

Mr. Hermann pinpointed "semantics" as possibly the largest trouble area. He said: "A medical term may not mean the same to two doctors and may have several different meanings. In addition, although a new term may be invented after a certain amount of usage, it may take on different shades of meaning."

The use of several different terms to describe the same condition, he said, could also creat problems. "The result is that the computer even where it is operating with full text and machine indexing in the present state of development, cannot bring up all relevant information bearing upon a problem."

Other malpractice suits, the attorney pointed out, could arise from failure of the computer to assist due to a mechanical breakdown, or errors made by the operator or in the program.

In closing, Mr. Hermann said that "the impact of the computer upon patient, doctor, and hospital is bound to be profound."

"It is inevitable that significant impact will also occur in medical and hospital malpractice," he stated. "The new technology may well call for new rules. Certainly the courts may be called upon to decide many new questions and the criteria for measuring medical and hospital malpractice may change just as drastically as the computer may change the entire field of medical and hospital practice."

Surgeons Announce Paper Competition

International Surgery, the official journal of the International College of Surgeons, has announced a cash award of $500.00 for the best scientific paper submitted by a surgical resident.

The award is being made available through a grant from Carroll J. Bellis, M.D., a Fellow of the International College of Surgeons who practiees general surgery in Long Beach, Calif.

Residents in general surgery or any of the surgical specialties in Pennsylvania entering the competition should stress in their manuscripts the clinical aspects of surgical science.

Scientific articles being entered must be original and must not have appeared elsewhere in print. They must be typewritten, double-spaced and submitted in duplicate.

Bibliographies should be presented alphabetically, cover all referenees cited in manuscript and contain the following information: names and initials of all authors; full title of article or book; name of book's publisher, city and year published; name of periodical, volume number, page and year of publication.

All illustrations should have following information appearing on the reverse side: author's name, figure number and the "top" clearly indicated. Captions must accompany illustrations and the approximate position in the text for the illustrations should be indicated. Slides are not acceptable. Captions for photomicrographs should give magnification and stain.

All manuscripts must arrive by November 30, 1969, at the offices of the Surgical Resident Award Program, *International Surgery,* 1516 N. Lake Shore Drive, Chicago, Illinois 60610.

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Kolantyl Gel/Wafers contain antacids, and Bentyl® (dicyclomine hydrochloride) too.

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(0715)

State Sewage Facilities Planning Progresses

Sewage facilities planning under the 1966 State Sewage Facilities Act is progressing well throughout the Commonwealth, a State Health Department official reported recently.

"But, enforcement, because of last year's amendment to the law, is in a state of confusion," Wesley E. Gilbertson, deputy secretary for environmental protection, told a clean streams symposium.

Since the passage of Act 177, enforcement by local governing bodies has been eliminated in the 1,500 state municipalities with a population density of less than 300 per square mile, according to Gilbertson. Many such municipalities which were exempted by the amendment are not developing plans, he added.

He said passage of House Bill 587 would restore enforcement to the municipalities in a clear-cut manner and provide for permits for all individual sewage disposal systems except rural residences on ten or more acres.

The Sewage Facilities Act is designed to eliminate water pollution and health hazards from septic tanks, overflowing cesspools and hidden discharges to creeks by requiring municipalities to plan for the orderly development of public sewerage systems.

Thus far, sixty-one counties have prepared comprehensive sewerage plans for 2,404 of the state's 2,559 municipalities, Gilbertson reported. He said that in the remaining counties, municipalities will prepare individual official plans.

Four county-wide plans representing a total of 184 municipalities have been approved by the State Health Department. At present, fourteen county plans are being reviewed with twenty-three others expected before the end of the year. Another twenty-two county plans under preparation should be reviewed before December, 1970, he estimated.

Thus far the department has authorized $742,770 in grants to counties and municipalities to assist them in preparing official plans. The appropriation bill for the fiscal period 1969-70 would provide $100,000 for planning assistance, according to Gilbertson.

Planning under other new legislation—the Solid Waste Management Act—is getting underway, he reported. The law provides for the planning and regulation of solid waste storage, collection, transportation, processing and disposal systems.

Fifteen counties and four multi-county areas have informed the department that they will carry out solid waste planning on behalf of local jurisdictions. Of these, seven projects were funded last fiscal year.

Gilbertson described the state's solid waste program as unique in that the protection of water and air quality must be observed.

Oral Surgical Benefits

Blue Shield Expands Coverage

Pennsylvania Blue Shield expanded its oral surgical benefits to include payment for services performed in the dentist's office, effective October 1, it has been announced by Matthew K. Gale, president.

Since 1949, Blue Shield has covered certain procedures only if performed when the subscriber was a patient in an accredited hospital.

The extended and revised coverage —regardless of whether the service is performed in a dentist's office or a hospital—will include:

Cutting procedures for treatment of diseases, injuries, fractures and dislocations of the jaw and extraction of impacted teeth when partially or totally covered by bone.

Services not covered include normal care and extraction of teeth and these oral surgical procedures: alveolectomy, dental root resection, gingivectomy, root canal treatment and extraction of soft tissue impactions.

Most Blue Shield subscribers received the expanded benefit at no additional cost. About 3.3 million subscribers were covered on the effective date and 1.7 million more will have the new benefit when it is included in their master contracts.

"New oral surgical techniques and more readily available dental facilities outside hospitals make it increasingly evident that many oral surgical procedures formerly requiring hospitalization are now successfully performed in dentists' offices," Gale said, "This fact, plus the probable elimination of unnecessary hospital admissions which will help reduce over-all health care costs, led Blue Shield to provide the expanded benefit for its subscribers."

Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G; prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization) Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria, serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units). Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL PEN•VEE® K

(potassium phenoxymethyl penicillin) Wyeth®

Health Centers Best Training For Family Physicians

Neighborhood health centers are proving to be the best locations to train physicians in family medicine because, in the opinion of a Temple University physician, that is where the action is in the health care field.

Arthur D. Nelson, M.D. director of comprehensive health services for the Philadelphia university, told the American Medical Association's section in general practice at the AMA convention.

"In the case of neighborhood health centers, that's where one finds the patients in need of continuing comprehensive care. Isn't that what family practice is all about? If we are to come to grips with the problems of organization, distribution and manpower, our physicians must be trained in a setting dedicated to solving these dilemmas."

Dr. Nelson was instrumental in planning the comprehensive community health services project directed by Temple, which operates two centers in North Philadelphia funded by the Office of Economic Opportunity.

(The centers are West Nicetown-Tioga section at Seventeenth and Tioga Sts. and in the Hartranft area on Germantown Ave.)

"Here we can truly determine the content of family practice," he said. "We can evaluate the incidence of disease entities while we study the ecology of a given community."

The recognition this year of the speciality of family medicine, and the establishment of a certifying board of family practice should reawaken interest in this critically important field.

Where other specialties train their candidates in depth, this new discipline will require a breadth of education adequate to meet the comprehensive care needs of the individual in his family and community setting.

Dr. Nelson also noted that the consultants on the staffs of the centers are backed up by specialists from Temple University Hospital and its medical school.

This combination, he said, "is the greatest asset we have" in helping the family physician solve his daily problems.

"This approach to family practice within the neighborhood where the patients are, and in a setting where educational inputs are available is the right place to concentrate training in family practice," he said.

In both centers, he explained, there is heavy reliance on a cooperative arrangement between neighborhood boards of directors and the center's professional staff. He said physicians are beginning to understand the "logical expansion of the intimate partnership between the physician and the patient, which we accept, into the larger partnership between the profession and the society it serves."

Physicians, he added, are learning that the community is in the best position to define its problems and goals in the delivery of health care. Until now, it has made no encroachment upon the professional's prerogatives in the field of technological expertise.

'You Have Changed My Boy to Girl. Will This Make Much Difference?'

Health insurance companies receive some of the most unusual letters.

Some choice correspondence from a large Chicago-based insurance company, provides the following samples:

• "I am forwarding my marriage certificate with my three children, one of which was a mistake as you will see."

• "You have changed my little boy to a little girl. Will this make a difference?"

• "Unless I get my husband's money very soon I will be forced to lead an immoral life."

• "This is my eighth child. What are you going to do about it?"

• "In accordance with instructions, I have given birth to twins in the enclosed envelope."

• "I want money as quick as I can get it. I have been in bed with the doctor for two weeks and it hasn't done me no good. If things don't improve I will have to send for another doctor."

• "I have no children as yet as my husband is a bus driver and works night and day."

• "I am writing to say my baby was born two years old. When do I get my money?"

• "I am glad to report that my husband who was reported missing is dead."

• "In answer to your letter, I have given birth to a boy weighing ten pounds. I hope this is satisfactory."

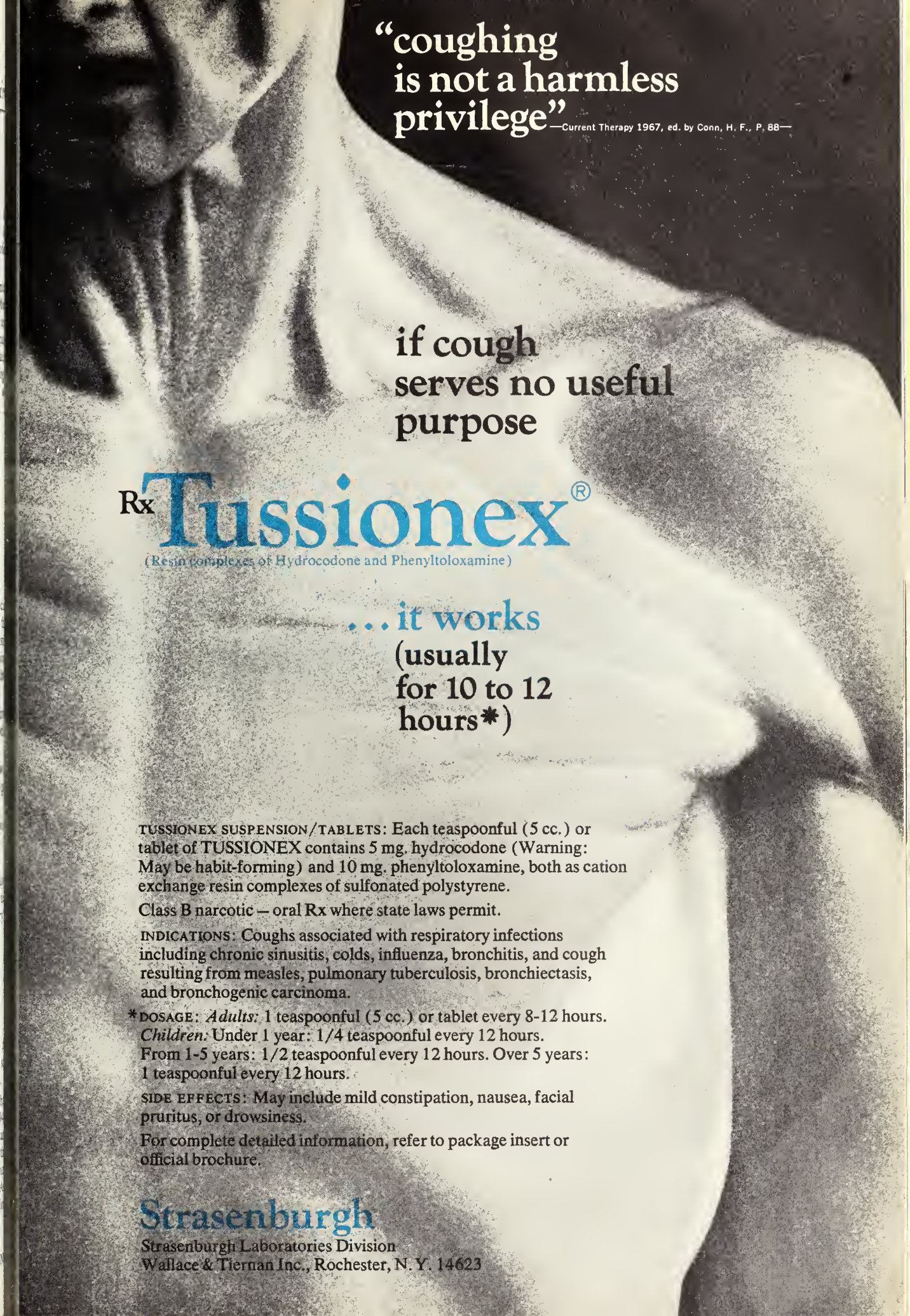
State Appoints Health Consultant

Lt. Col. John E. Rowland, Fort Belvoir, Va., has been appointed comprehensive health planning consultant with the Pennsylvania Department of Health.

Rowland will coordinate the activities of the state's regional comprehensive health planning agencies and will be located in the central office in Harrisburg.

Rowland will assist the regional agencies in guiding the planning of local hospitals, clinics, professional societies and voluntary organizations.

A native of Altoona, Rowland has been with the U.S. Army since 1948 in various positions of hospital management. He is a member of the American College of Hospital Administrators, the American Hospital Association and the Hospital Association of Pennsylvania.



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

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His heart tells him he's an invalid.
You know he's not.

Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

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nxiety is expected in the cardiovascular patient. A little may even be desirable.

ut when anxiety is exaggerated . . . when it terferes with sleep . . . when it aggravates rdiovascular symptoms, your help may e needed.

aturally, you'll want to reassure the patient.

nd perhaps prescribe Equanil (meprobamate) adjunctive therapy. It helps relieve anxiety d tension specifically, yet gently.

most 15 years' use has shown that Equanil usually well tolerated as well as effective. de effects are generally limited to transient owsiness; serious, therapy-interrupting de effects are rare.

Equanil®

(meprobamate) Wyeth®

No place for beginners

Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

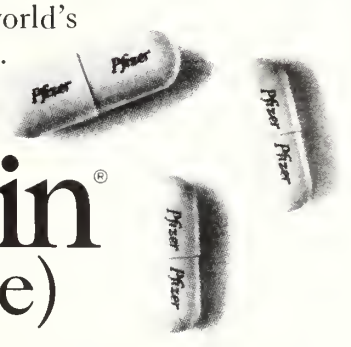
Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



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newsfronts

SVRMP Considers Rheumatic Fever Control Plan

Preliminary consideration has been given to a Rheumatic Fever Control Program for a seventeen-county area of Pennsylvania by members of the northeastern area committee of the Susquehanna Valley Regional Medical Program.

Meeting at Shamokin Dam, the committee composed of doctors, hospital administrators, nurses and other health workers expressed its approval of the program, which would be administered by the Northcentral Heart Association.

The object of the program would be to demonstrate the value of throat cultures in the diagnosis of streptococcal infections. Throat culture kits would be distributed to physicians throughout the area and the effectiveness of a convenient laboratory procedure for accurate diagnosis and appropriate follow-up on all positive cultures would be demonstrated. The area involved includes a population of more than a million people.

The program recently received the approval of SVRMP's Appalachian-Highland Area, and will be considered by the six-county northern area next week. It will then be studied for its scientific merit by the SVRMP's Council on Heart Disease, before being considered by the Regional Advisory Group for a final decision as to whether the project should be submitted to the federal level for approval and funding.

Robert F. Dickey, M.D., of Danville, vice-chairman of the area committee, reported on the progress of six projects in the northeastern area which have already been funded through SVRMP. These include a nurses' training program in coronary care at Geisinger Medical Center, Danville; coronary care unit equipment and training for doctors and nurses from Sunbury Community Hospital, Evangelical Community Hospital of Lewisburg, Good Samaritan Hospital of Pottsville, and Shamokin State General Hospital; and the Susquehanna Valley Home Health Service, which involves Snyder, Union and northern Northumberland Counties.

James Kirk, administrator of Pottsville Hospital, J. Mostyn Davis, M.D., Shamokin general practitioner, and Charles A. Laubach, Jr., M.D., chief of the cardiovascular and pulmonary disease section at Geisinger Medical Center, reported on several projects which are being developed within the Northeastern Area counties of Columbia, Montour, Northumberland, Schuylkill, Snyder and Union.

The committee voted to return its three incumbent representatives to the SVRMP's Regional Advisory Group. They are: Dr. Davis; Thomas P. Buckley, M.D., pathologist at Good Samaritan Hospital in Pottsville, and Ellsworth R. Browneller, M.D., administrative director of Geisinger Medical Center.

Phila. Cancer Research Institute Accredited

The Institute for Cancer Research, Philadelphia, has been accredited by the American Association for Accreditation of Laboratory Animal Care. The institute was one of sixteen newly accredited institutions, bringing the total certified to 135. This first list of accredited facilities was published in 1968. Application for accreditation is voluntary, and the purpose of the association is to maintain high standards for the care of laboratory animals, and to provide a means of self-regulation by the scientific community.

HOW INFORMED MUST CONSENT BE?

Informed consent by the patient being prepared for surgery can be carried to an extreme. Paul Huffington, M.D., Easton, Maryland, told the Maryland State Bar Association a typical extreme session with a patient might go like this:

"Good evening, Mrs. X. I am Dr. Y, your anesthesiologist. The nurse tells me that you are somewhat apprehensive about having anesthesia. . .

"I'll tell you exactly what we are going to do so that there will be no difficulty. I will give you several pills in the morning to take the edge off your nerves. You will then be brought to the operating room where I will see you. We will put a blood pressure cuff on your arm and a needle in your vein.

"I will put you to sleep with Pentothal, administered in your vein. After you are asleep, I will paralyze you with curare and place a tube in your windpipe. I will use cyclopropane, a general anesthetic, to keep you anesthetized throughout the operation.

"As you know, you are having your stomach removed, so I will breathe for you throughout this operation, which usually lasts for about three and one-half hours. General anesthetic will depress your heart appreciably, affect your liver adversely from three to five days, halve your blood facilities to your vital abdominal organs, and the chance of your lung collapsing, or a part of it, is about 10 to 40 percent, depending upon the literature you read.

"During the operation, I will have to decide how much blood and fluid to give you, but usually two pints of blood and three quarts of solution are required. At the end of the operation, I will give you some potent medicine that temporarily poisons your enzymes, so that the curare will no longer be effective.

"After getting you breathing on your own, I will remove the tube and make sure you don't stop . . . because of airway obstruction.

"I then will move you into the recovery room and give you potent pain killing drugs and drugs to prevent your vomiting. I hope that by explaining my responsibilities, I have set your mind at ease, and you will sleep well tonight."

(Reprinted from the August, 1969, edition of ASA NEWSLETTER).

"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.

Woman's Medical Establishes Child Psychiatry Residency

Leo Madow, M.D., professor and chairman of the department of psychiatry and neurology at Woman's Medical College of Pennsylvania, has announced the establishment of a new Child Psychiatry Residency Training Program to be conducted jointly by the college and Eastern Pennsylvania Psychiatric Institute.

The new program will be under the directorship of Robert C. Prall, M.D., who has headed the EPPI residency training program for many years. According to Dr. Madow, Dr. Prall has developed a program which will now be expanded by the addition of WMC's Child Psychiatry staff and its activities headed by Selma Kramer, M.D. She is clinical professor of child psychiatry and chief of the section in child psychiatry as well as chairman of the Child Psychoanalytic Faculty of the Philadelphia Psychoanalytic Institute.

Under the WMC-EPPI Child Psychiatric Residency Training Program, previous teaching activities of the EPPI Children's Unit will be continued and the program expanded to cover consultations in pediatrics and other services at WMC's Hospital as well as the activities of WMC pediatric department's comprehensive child care program.

The new program will continue to cooperate fully with other state hospital programs providing opportunities for training in child psychiatry and other state adult psychiatric residency programs. In addition, it will work closely with the college's adult psychiatric residency training program under the direction of O. Eugene Baum, M.D., WMC professor of psychiatry.

Dr. Prall, as director of the new joint child psychiatry residency training program, has been appointed clinical professor of child psychiatry at the college and will assist with other departmental activities.

Dental Director Supports Fluoride In State Waters

Noting that more than four and a half million Pennsylvanians served by public water supplies are currently receiving the "proven benefits of controlled fluoridation," a state health department dental health executive recently reaffirmed the department's support of fluoridation as a "highly desirable public health measure."

Dr. David R. Wallace, Director of the Division of Dental Health, said that since his department first endorsed the principle of fluoridation in 1951 as a way to reduce tooth decay in children by as much as 65 per cent, installation of approved fluoridating equipment in the Commonwealth's public water supplies has expanded steadily.

According to Dr. Wallace, recent figures show that 54.47 per cent of Pennsylvanians now served by public water systems are receiving fluoridated water. This percentage will rise, he said, when equipment installations under way in a number of additional communities are completed.

Observing that this progress has been made in the face of frequently strenuous opposition, Dr. Wallace declared that he is "at a loss" to explain the reasons behind such opposition since "every reliable and reputable dental, medical and public health agency in Pennsylvania and the United States recommends and endorses fluoridation."

Dr. Wallace said that he is in full accord with Dr. V. L. Diefenbach, director of the federal dental health division, who urged recently that top priority be given toward revitalizing the movement to fluoridate all community water systems and rural school water supplies.

HEW Grant Awarded

Better Family Planning, Inc., Philadelphia, is the recipient of a grant of $316,667, Secretary Robert H. Finch of the Department of Health, Education, and Welfare announced recently. The grant was one of seventy-nine extending family planning services to the poor in forty-one states. The grants, administered by the Children's Bureau, are authorized under the 1967 amendments to Title V of the Social Security Act. Herbert J. Hutton is project director for the Philadelphia recipient of the federal aid.

Decade Sees Medical School Growth, Says Report

The decade between 1958 and 1968 has seen a more rapid growth in the development and expansion of new and existing medical schools in the United States, according to a recent study made by the Association of American Medical Colleges. Since 1958, nine new medical schools have opened their doors, six of which were established in 1965 or thereafter. By comparison, prior to 1958, nine new schools were organized over the period from 1930 to 1958.

From 1958 to 1968 total enrollment in all medical schools increased by 4,924 students, and in 1968 medical schools graduated 7,973 physicians, 1,113 more than in 1958.

In 1967, the level of total expenditures for medical schools rose to $1,010 billion, or an increase of 216 per cent of $691 million over 1958. As seen in Figure 1, the larger proportion of this increase is attributed to sponsored programs expenditures which rose from $144 to $581 million. During this same period, expenditures for regular operating programs rose by 145 per cent, from $174 to $429 million.

Average basic operating expenditures per undergraduate medical student rose from $5,902 to $12,841 between 1958 and 1967. However, only some of this increase can be legitimately charged to the education of medical students. Factors contributing to the rising costs are: increased obligations for participation in health related instruction on behalf of the university; new responsibilities for the delivery of health care to the community; new interest in the provision of continuing education programs and increased faculty responsibility for postgraduate education of scientists and physicians. These have required a rapid expansion of human resources which are reflected in increasing costs. Only until methods for analysis of program costs are in general use can full insight be given into the relationships between total expenditures and medical student output, according to the AAMC report.

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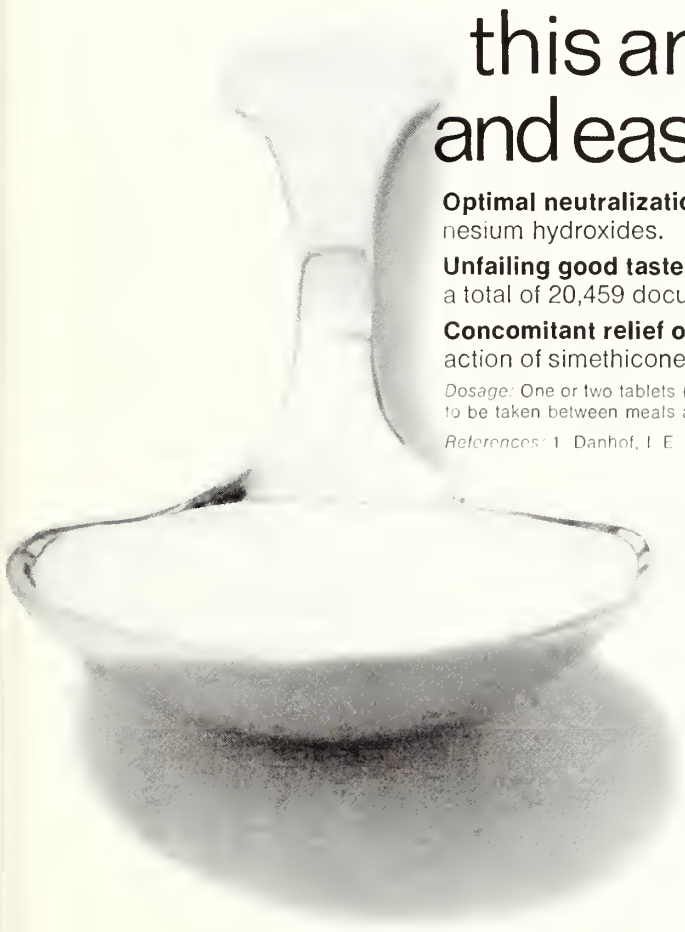

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References: 1. Danhof, I. E. Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

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COMPREHENSIVE HEALTH PLANNING

Comprehensive health planning and the regional medical programs, two federal projects directed toward improving health care services, use different approaches to reach the same goal.

Comprehensive health planning involves both the consumer and provider

COMPREHENSIVE HEALTH PLANNING

PURPOSES

To establish a process to achieve Comprehensive Health Planning on a state-wide basis which identifies health problems within the state, sets health objectives directed toward improving the availability of health services, identifies existing resources and resource needs, relates the activities of other planning and health programs to meeting these health objectives, and provides assistance to state and local officials, to private voluntary health organizations and institutions, and to other programs supported by U. S. Public Health Service grant funds toward more effective allocating resources in accomplishing the objectives.

PARTICIPANTS

State agency, placed in the department of health by the governor, does the planning. State advisory council advises on the health priorities of the state. The majority of council members must be consumers. The members come from voluntary health groups, professional societies, public agencies, general planning agencies, and universities.

PROCEDURES

1. Establish state and areawide health goals.
2. Define total health needs of all people and communities in state.
3. Inventory and identify relationships among varied local, state, national, governmental and voluntary programs; regional medical programs, mental health, health facilities, manpower, medicare—in order to assist these programs in making a more effective impact with their resources.
4. Provide information, analyses, and recommendations which can serve as the basis for the Governor, other health programs and communities to make more effective allocations of resources in meeting health goals.
5. Provide a focus for interrelating health planning with planning for education, welfare and community development.
6. Support the initiation and integration of pilot projects for better delivery of health services; develop plans for targeting flexible formula and project grants at problems and gaps.

AND REGIONAL MEDICAL PROGRAMS

of health services in coordinating the planning activities of health facilities, voluntary groups, societies, and other health organizations. The regional medical programs involve health providers in establishing new services for the consumers. Here is a more detailed explanation of the two projects.

REGIONAL MEDICAL PROGRAMS

PURPOSES

To identify regional needs and resources relating to heart disease, cancer, stroke, and related diseases and to develop regional medical programs which utilize cooperative arrangements to apply and strengthen resources in making more widely available the latest advances in diagnosis and treatment of these diseases.

PARTICIPANTS

University medical centers, hospitals, practicing physicians, other health professions, voluntary and public health agencies, and members of the consumer public. A regional advisory group representing these interests and playing an active role in the development of the regional programs must approve any application for operational activities of the regional medical programs.

PROCEDURES

1. Establish cooperative arrangements among science, education, and service resources.
2. Assess needs and resources.
3. Develop pilot and demonstration projects, emphasizing flow of knowledge in uplifting the cooperative capabilities for diagnosis and care of patients.
4. Relate research, training, and service activities.
5. Develop effective continuing education programs in relation to other operational activities.
6. Develop mechanisms for evaluating effectiveness of efforts in the provision of improved services to patients with heart disease, cancer, stroke and related diseases.

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3. Cites synergism between androgen and thyroid.
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Thiamine HCL	10 mg.

Dose 1 tablet 3 times daily.
Available: Bottles of 100, 500, 1000.

Android-X

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Each orange tablet contains:

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Dose: 1 or 2 tablets daily.
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Thiamine Hydrochloride	10 mg
Glutamic Acid	50 mg

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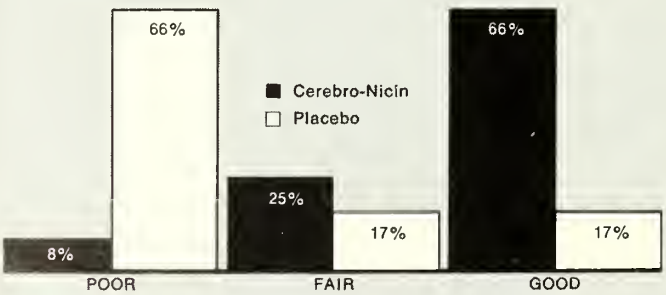

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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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close-up/MD's

Sidney O. Krasnoff, M.D., of Wyncote, an internist, has been elected to a two-year term as chairman of the medical staff board of Philadelphia's Albert Einstein Medical Center. The announcement was made by **Pascal F. Lucchesi, M.D.,** Einstein's executive vice president and medical director. Other medical staff board officers chosen to serve with Krasnoff were: **Bernard B. Zamostien, M.D.,** of Bala-Cynwyd, a general practitioner, vice chairman; **Arthur L. Schneeberg, M.D.,** of Elkins Park, a urologist, treasurer, and **Henry J. Dudnick, M.D.,** of Chestnut Hill, an internist, secretary. All three were elected for two-year terms.

DR. KRASNOFF

Three Philadelphia educators are the authors of major articles in a special "Symposium on Medicolegal Problems" in a recent issue of *Modern Medicine*. Sidney H. Willig, J.D., professor of law at the Institute for Law and the Health Sciences, Temple University, was guest editor for the Symposium and wrote the introduction and an article entitled "Medicolegal Implications of Federal Drug Regulation." Other Philadelphia contributors were **Jonas Robitscher, M.D., J.D.,** a psychiatrist at Lankenau Hospital and the University of Pennsylvania School of Medicine, and Samuel Polsky, Ph.D., LL.B., professor of law and legal medicine, director of the Institute of Law and Health Sciences, and co-director of the unit in law and psychiatry at Temple University.

DR. ROBITSCHER

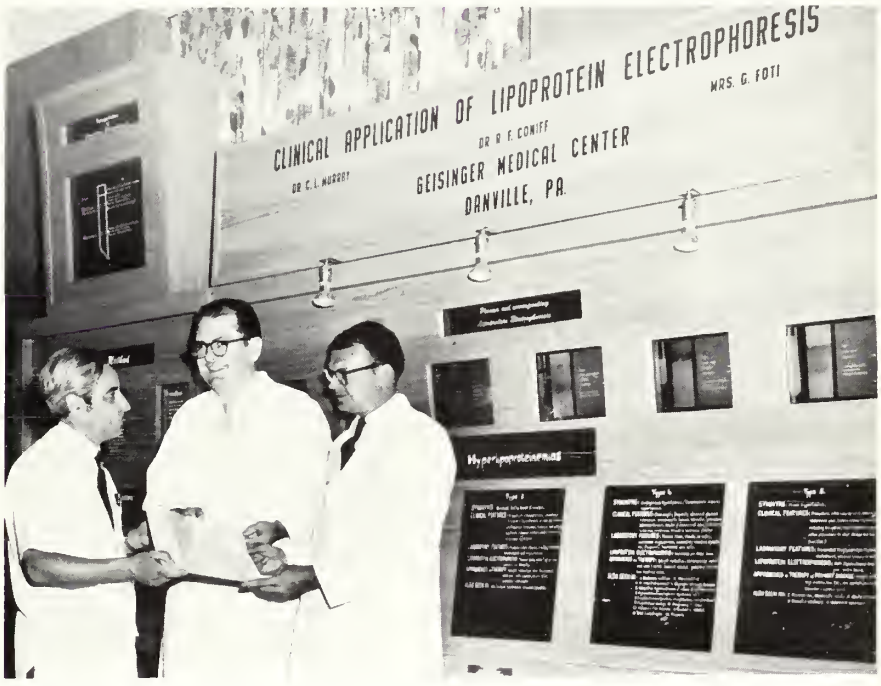
Dr. Robitscher, who also is a faculty member at Villanova University School of Law, wrote an article entitled "The Doctor as an Occasional Witness."

Clyde B. Lamp, Jr., M.D., has been elected president of the Pittsburgh Otological Society for the 1969-70 term. Serving with him are **Ralph J. Caparosa, M.D.,** vice-president; and **Bruce B. McMillan, M.D.,** secretary-treasurer.

Joseph U. Toglia, M.D., Philadelphia, Associate Professor Neurology and Otorhinology at Temple University Hospital, delivered a paper entitled, "Post-Traumatic Dizziness, Electro-Nystagmographic Study of 250 Patients," at the International Congress of Otorhinolaryngology in Mexico City.

J. A. Perrone, M.D., Pittsburgh, chief of laryngology and bronchoesophagology, Mercy Hospital, presented a paper at the recent meeting of the International Association of Laryngectomees in Pittsburgh, entitled "Will Larynx Transplant Replace Laryngectomy?"

Audrey Evans, M.D., has been appointed pediatric oncologist at The Children's Hospital of Philadelphia, **Alfred M. Bongiovanni, M.D.,** physician-in-chief, has announced. Dr. Evans also was named associate professor of pediatrics at the University of Pennsylvania School of Medicine by Dr. Bongiovanni, who is William H. Bennett professor and chairman of the department of pediatrics at the university.



Two physicians *on the staff of the Geisinger Medical Center, Charles F. Murray, M.D. and Robert F. Coniff, M.D., both of the department of internal medicine, were awarded a certificate of merit for a scientific exhibit at the Annual Meeting of the American Medical Association, held in New York City. The subject of the exhibit was "Lipoprotein Electrophoresis in the Diagnosis and Management of Serum Lipid Abnormalities," and it presented, in a series of slides, a simplified method for diagnosing serum lipid disorders. There were more than 230 scientific exhibits on display at the convention and the awards were made at a dinner before an audience of more than 500 physicians from all sections of the United States. Harald H. Richter, director of medical photography at Geisinger, left, and his staff prepared the transparencies and artwork for Dr. Murray, center, and Dr. Coniff, right, and assisted in the design of the exhibit.*

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Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

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close-up/MD's

WELCOME, NEW MEMBERS!

These M.D.'s have joined the State Society in recent months:

BERKS COUNTY:

CHUNG H. CHO, M.D., Community General Hospital, Reading 19601.

CLODUALDO S. ORQUIZA, M.D., 225 N. Sixth St., Reading 19601.

FAYETTE COUNTY:

PHILLIP E. REILLY, M.D., 217 Dixon Blvd., Uniontown 15401.

PHILADELPHIA COUNTY:

IVAN D. BARONOFSKY, M.D., 230 Broad St., Philadelphia 19102.

JOHN B. CAPELLI, M.D., 1 Oak Court, Stratford, N.J. 08084.

HARRY D. CARROZZA, M.D., 5735 Ridge Ave., Suite 205, Philadelphia 19128.

FRANCIS E. CONRAD, M.D., 3300 Henry Ave., Philadelphia 19129.

DAVID S. ELKINS, M.D., 8040 Rowland Ave., Philadelphia 19136.

ZBIGNIEW J. FILIP, M.D., 1000 Walnut St., Apt. 507, Philadelphia 19107.

NICHOLAS S. GIMBEL, M.D., 43 University Mews, Philadelphia 19104.

JUNG-CHING LIU, M.D., 1930 Mather Way, Philadelphia 19117.

ROBERT T. MACKOWIAK, M.D., 7201 Shalkop St., Philadelphia 19128.

BIENVENIDO MATOS, M.D., 48 Lanfair Rd., Ardmore 19003.

PETER V. MOULDER, JR., M.D., Pennsylvania Hospital, Eighth and Spruce Sts., Philadelphia 19107.

GHASSEM NIKNEJAD, M.D., 3300 Henry Ave., Philadelphia 19129.

DIANE E. PEARSON, M.D., Philadelphia Psychiatric Center, Philadelphia 19131.

MARTIN RUBEL, M.D., Philadelphia Psychiatric Center, Philadelphia 19131.

HABIB TONSEY, M.D., 3374 Byberry Road, Philadelphia 19154.

SOMERSET COUNTY:

PAUL R. WOOLSLAYER, M.D., 208 Sherman St., Meyersdale 15552.

SUSQUEHANNA COUNTY:

EDWARD R. MORACCO, M.D., 400 Turnpike St., Susquehanna 18847.

STEPHEN B. SCHER, M.D., 1 Grow Ave., Montrose 18801.

WARREN COUNTY:

GUIDO D. BORIOSI, M.D., Warren State Hospital, North Warren 16365.

In the Commonwealth

Physicians Express Concern at Air Pollution Hearings

A number of physicians were among Pennsylvanians who jammed auditoriums on September 9 in Pittsburgh, and September 10 in the Philadelphia area to hear, or participate in, almost unanimous criticism of the Commonwealth's proposed amendments to Pennsylvania's Ambient Air Quality Criteria.

Leading the list of scientists, engineers and doctors who spoke against the Pennsylvania Air Pollution Commission's proposals in Pittsburgh was Warren Winkelstein, M. D., professor and head, department of epidemiology, University of California School of Medicine. He headed the Public Health Service committee which established standards to guide the states in their decisions.

At the Philadelphia hearing, Katharine Boucot Sturgis, M. D., delivered a statement on behalf of the 4,000-member Philadelphia Medical Society. Her testimony appears below. Also appearing to request that the Commonwealth submit better standards to PHS for its approval were Charles E. Myers, M. D., representing the 700-member Pennsylvania Thoracic Society, and Peter A. Theodos, M. D., of the Philadelphia Tuberculosis Association.

The Philadelphia Medical Society, through its secretary, Valentine R. Manning, M. D., has submitted a resolution on the subject to be considered by the PMS House of Delegates at its 1969 Annual Session.

STATEMENT BY KATHARINE BOUCOT STURGIS, M.D.
BEFORE THE COMMONWEALTH OF PENNSYLVANIA
AIR POLLUTION COMMISSION AT
THE PUBLIC HEARING SEPTEMBER 10, 1969

I, Katharine Boucot Sturgis, immediate past president of the Philadelphia County Medical Society and current chairman of its Committee on Air Pollution Control, appear at this public hearing on Pennsylvania's proposed standards for sulfur dioxide and particulates on behalf of the more than 4,000 physician-members of our society. I am chief editor of the American Medical Association's journal, *Archives of Environmental Health,* and emeritus professor of preventive medicine of Woman's Medical College of Pennsylvania.

The members of the Philadelphia County Medical Society are deeply concerned about the increasing incidence of respiratory disease, particularly chronic bronchitis, emphysema, asthma, and cancer of the lung.

Ample evidence exists associating acute air pollution episodes in which particulate and sulfur dioxide levels were high with worsening and even death of individuals with chronic cardiorespiratory disease, especially older persons.

Epidemiologic studies in the United States, Canada, and Great Britain reveal a higher prevalence of lung cancer, chronic bronchitis, and emphysema in areas of high compared with areas of lower pollution. Similar studies in several United States cities showed a higher percentage of hospital emergency room visits for asthmatic attacks on days of increased air pollution.

The major problem which faces us in recommending maximal exposures for ambient air is our lack of methodology for studying the long term effects of low levels of pollutants. As in the early days when the adverse effects on health of smoking were only suspected, we do not yet have sufficient data to prove all aspects of the case against the increasing levels of pollutants being recorded in our cities. However, it is the clear moral duty of physicians, the citizens most acutely aware of the increasing cardiorespiratory disease among us, to testify at these hearings.

We urge that, not only should the criteria for sulfur dioxide and particulates set forth by the Public Health Service be considered, but that safety factors be built into Pennsylvania air quality standards. We should guard against the not yet fully gauged, subtle, long term health effects of sulfur dioxide and particulates, setting standards which, later, may be raised with safety rather than setting standards which will undoubtedly require lowering as will the standards currently proposed by the State of Pennsylvania. For instance, the proposed sulfur dioxide standards set 0.03 ppm, or 86 μg/m3 for the maximum annual level is the precise level at which plant injury and excessive leaf drop may occur. Should we not consider it likely that such a level will endanger the gossamer walls of the air sacs of the lungs where carbon dioxide removal and absorption of oxygen take place? We believe that the experimentally demonstrated narrowing of the smallest bronchi when sulfur dioxide adsorbed on particulates enters them is a factor in tearing the air sacs beyond the constriction. Such disruption of air sacs is the major feature of the dreadfully chronic and incapacitating lung disease, emphysema, which has become the second largest cause of disability payments according to Social Security records. Is it reasonable to disregard the costs of such human suffering and disability in attempting to cushion the costs of control measures for a few industries? In May, 1968, before ever the federal criteria were issued our neighboring state of New Jersey set her own regulations for allowable sulfur content in coal and oil. These have been applied and over the ensuing year and a half, the levels of sulfur dioxide in the ambient air are being reduced. The full impact of the New Jersey regulations will be reached by 1971 when New Jersey levels will drop to the levels which the state of New Jersey will propose at its New Jersey hearings September 22, 1969.

The 30 day maximum concentration of 0.05 ppm (143 μg/m3) for sulfur dioxide proposed by Pennsylvania is associated with a four-day maximum range of 281-283 μg/m3. This certainly provides an inadequate margin of safety since, at 300 μg/m3, increased hospital admissions and increased industrial absenteeism have been documented. The 24 hour maximum concentration of 0.25 ppm (715 μg/m3) has an associated 4 day maximum range of 443-553 μg/m3 which also exceeds the level at which increased hospital admissions and absenteeism occurs. The proposed one hour maximum of 0.50 ppm (1430 μg/m3) with a 4 day maximum range of 293-540 μg/m3 again exceeds the criteria level at which adverse health effects are noted.

The case is just as clear for (annual concentration—100, 30 day—150, 24 hour—300 μg/m3) particulates, Pennsylvania's proposals all exceed the 80 μg/m3 level at which increased deaths can be expected. Pennsylvania's long range goal is 80 μg/m3 but is said to be unrealistic at present. We as physicians, cannot accept that philosophy. The Pennsylvania proposed 24 hour maximum with a median of 30(

μg/m3 is the level at which patients with chronic bronchitis note worsening of cough and sputum, sometimes acute worsening.

Instead, we recommend the following:

For Total Suspended Particulates

1. Maximum value for any 24-hour period—195 μg/m3
2. Maximum value for any 24-hour period during any 12 consecutive months—195 μg/m3 on not more than one occasion
3. Median value for all 24-hour concentrations during any 12 consecutive months not to exceed 65 μg/m3

For Sulfur Dioxide

I. a. Maximum value for arithmetic average during any one-hour period—668 μg/m3 (0.25 ppm)
   b. Arithmetic average concentration during any one-hour period during any consecutive 12-month period may attain but not exceed 668 μg/m3 (0.25 ppm) no more than once
   c. Arithmetic average concentration during any one-hour period during any consecutive 12-month period may attain but not exceed 534 μg/m3 (0.20 ppm) no more than nine times.

II. a. Maximum during any 24-hour period—267 μg/m3 (0.10 ppm)
   b. Arithmetic average concentration during any 24-hour period during any consecutive 12-month period may attain but not exceed 267 μg/m3 (0.10 ppm) no more than once.
   c. Arithmetic average concentration during any 24-hour period during any consecutive 12-month period may attain but not exceed 214 μg/m3 (0.08 ppm) no more than four times.

III. a. The arithmetic average concentration of sulfur dioxide during any 12 consecutive month period shall exceed 53 μg/m3 (0.02 ppm)
   b. The median value of all one hour or 24 hour periods during any 12 consecutive month period shall not exceed 45 μg/m3 (0.017 ppm).

These levels are also recommended as standards by the state of New Jersey. Thus, they would have the added virtue of simplifying standards for the eleven-county Pennjerdel Region if Pennsylvania and New Jersey were to adopt them.

We protest the proposed standards set forth by the Commonwealth as inadequate to protect the health of our citizens. No safety factor is provided. No allowance is made for the enhanced adverse effects of combined sulfur dioxide *and* particulates referred to previously. We earnestly request a revision downward of the proposed Pennsylvania standards.

In the Nation

Private Insurers Hear Finch Challenge

Secretary Robert H. Finch of the Department of Health, Education, and Welfare has challenged the health insurance industry "including non-profit insurers," to mobilize itself to provide broader, more effective coverage; to change coverage to encourage preventive services which might keep people out of more expensive facilities; to expand to include additional groups and to play an active role in monitoring excessive use of scarce facilities, such as hospital beds.

He reported at a recent press conference that the Nixon administration will "move in the direction of reducing the Medicaid burden on general revenues by shifting to various forms of prepayment."

The secretary outlined an eleven-point program that would bring about important innovations in the health care system:

1. Eliminate the allowance to hospitals and nursing homes for unidentified costs;

2. Enforce regulations limiting payment to individual practitioners under Medicaid;

3. Increase reviews of drug utilization, pricing, efficacy and safety;

4. Direct the public health service to promote alternative medical care facilities;

5. Require tighter, more frequent reviews of hospital care for patients;

6. Require that physicians be identified by social security number in all Medicare and Medicaid transactions;

7. Establish an office of new carriers with top priority of developing programs for returning Vietnam medical corpsmen;

8. Propose Medicare and Medicaid legislation to bar practitioners who have abused the program, to insure that government does not pay more for services than the public at large, withhold reimbursement for facility expenses incurred contrary to a regional or local plan for health care facilities, and gain greater flexibility to engage in incentive reimbursement and demonstration projects;

9. Shift emphasis of the Hill-Burton Hospital Construction Project to the development of facilities for preventive and outpatient care, and the modernization of inner-city hospitals.

10. Reduce the burden of Medicaid on general revenues by moving to use various forms of prepayment;

11. Establish a secretary's task force on Medicaid and related programs (members have been appointed already) which will develop standards for medical care and utilization review procedures, develop methods to determine better eligibility requirements for medical and public assistance, and develop a stronger administration on the federal level to aid states and localities to maintain better controls of their programs and to develop technologies of medical assistance managements.

In Recognition of

CLEAN AIR WEEK

October 19-25, 1969

The steady and alarming increase in bronchitis and emphysema is of concern to most physicians in the United States. However, as a group we have been and continue to be remiss in our advocacy of those measures likely to reduce the incidence of these crippling and disabling diseases. No greater opportunity in preventive medicine presents itself today, yet as individual physicians we have not uniformly supported attempts to improve and to clarify the air we breathe.

Two prime target areas seem unmistakable. The first is the personalized do-it-yourself air pollution kit, the package of cigarettes. All physicians wanting to help their patients are obliged to bend ceaseless efforts to persuade them to stop smoking. Any compromising attitude on the part of a physician is taken as quasi approval by his patient.

The second target area is polluted ambient air, the kind floating in our towns, across our country, into our offices and homes. It is obvious that abrupt and acute pollution of environmental air is easily perceived and often easily corrected. Long term efforts are so insidious and gradual that they become difficult to define and just as difficult to control.

The State of Pennsylvania is presently attempting to define standards for pollutants which we recognize and can identify, although it must be appreciated that our ability to accomplish such identification is a recent development. All must acknowledge that we have had insufficient time to correlate in true scientific fashion the long term efforts upon health resulting from specific levels of pollutants. Furthermore, we need to be aware of the likelihood that there are other elements—still to be identified about whose effects we know nothing.

Nevertheless, a beginning must be made since under any circumstances protection of health should be considered a minimum requirement. And at this point in our knowledge we must deal with reasonable certainties and just as reasonable goals. From the physicians' point of view, we cannot justifiably introduce the concept of economic or industrial non-feasibility, because our permitted levels of pollution must be set at levels assuming protection of health.

The ambient air quality standards suggested by the Pennsylvania Department of Health include the annual limit of 100 micrograms/M^3 for suspended particulates and .03 ppm of sulfur dioxide. These values do not set goals appropriate for health protection. With respect to suspended particulates, increased death rates may be expected to occur at a level of 80 micrograms/M^3, while public awareness of pollution is likely to occur at about 70 micrograms/M^3. A permitted level of 100 micrograms is thus not consistent with what we know and with the declared goal of health protection. The .03 ppm for sulfur dioxide is also too liberal, since it exceeds the level at which increased hospital admissions and absenteeism from work may occur. It also exceeds the level at which chronic plant injury and excessive leaf drop may occur.

It must be acknowledged that the more stringent goals will be increasingly difficult to attain, but we are allowed a reasonable time to reach them. Furthermore, if we compromise with what is best for all of us, efforts to provide clean air will be compromised. Our responsibility is to future generations. The time to set the ship on its proper course is now. No greater opportunity in preventive medicine has ever been afforded and those responsible for setting rigid criteria dare not miss this opportuntiy.

CHARLES E. MYERS, M.D.
Chairman, Advisory Committee on Air Pollution, Pennsylvania Thoracic Society

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PENNSYLVANIA MEDICINE editorials

The Doctor and His Government

Two of the doctor's greatest areas of concern are his own medical associations and his own governments. We are herein proposing that much of the doctor's difficulty arises because of his erroneous posture in his relationship to these somewhat monolithic constructs. A change of attitude, some study and reflection and an active participation in his societies and in government at varied levels will prove to be a panacea.

The doctor is now much more involved with government at all its sites than was ever true in his past. This involvement is not likely to diminish. The huge public expenditures for health care at local, state and national levels are certainly not going to decrease in the near future and government will oversee its purchases.

There is no doubt that the government will continue to be deeply interested in the doctor's activity, level of performance, charges and productivity, as well as a hundred other things which we are used to thinking of as our private business. Medicine has moved into the public domain. In this respect, we must not fail to note that the concern of government arises as a mandate of *the people*. Our modern advances in scientific practice have made our fellow citizens able to envision a structure which will furnish the best available medical care for all—and fully paid for by methods which do not cut off or diminish care on the basis of ability to pay or on any other basis.

But the fact is that our abilities have been somewhat oversold; costs will continue to rise; there is no easy solution to the uneven distribution of medical care personnel; there is no way instantly to put a modern hospital fully staffed and equipped within the reach of every citizen. The extension and modernization of our hospital system and of our methods of medical practice so that we may give care at various echelons and by innovative methods is not a matter of months. Our fellow citizens will need to learn these facts and in the meanwhile are impatiently watching, complaining and waiting.

The active interest of the people in health care is easily seen in our home towns. There is widespread, if not always well informed, concern about a better supply of medical care. This is manifested in a variety of civic organizations. In such groups *planning* has become a kind of magic word for many people. It is, however, seldom a well reasoned process. Your fellow citizens interested in Community Service Planning Councils, in the programs of the Office of Economic Opportunity or of Model Cities, in inner city and ghetto problems-solving, in United Funds, in Hospital Boards and the like, are all ready to start planning to make improvements in our "health care system." They usually assume that a monistic system should supplant the pluralistic one which is our strength and our best bet for the future.

This interest of our fellow citizens is justifiable. But—physicians know by far the most about providing health care. They have, admittedly, not always taken a wide enough interest in the community's problems of costs, distribution, availability and related difficulties. We physicians must now act through our admirably structured county societies to join our fellow citizens in these plans for a more perfect future. Not only must the county society member take part in local discussions but every doctor should participate in such activities as Regional Medical Programs, Comprehensive Health Planning and others. Medical societies must be active in furnishing clinics, neighborhood health centers and migrant workers' clinics. They must be prime movers in maternal and perinatal programs, in the correction of local health care deficiencies and in various welfare and medical services as well as in volunteer programs in ghetto areas.

At the state level, too, there are multiple problems which call for study, reflection and participation by every practitioner. Here the problems are currently dwarfed by the difficulties which the states are finding in implementing Medicaid (Title XIX). But there is much else which calls for study. We need every doctor's participation and knowledge in state agencies concerned with the health department, with our state hospital agencies, with quackery, environmental health, with a state system of emergency medical care, with medical and paramedical licensure and the like. The doctor's freedom is touched upon in these and many other areas which are affairs of the state government. Every physician should be informed on these subjects and should be in contact with his state society officers and delegates, with his district councilor or even directly with his state society headquarters. Simultaneously, he should use his knowledge to guide and instruct the state legislators about medicine and health care.

Our Federal Government is most of all in need of our help and participation. National policies regarding many aspects of our professional life are being determined and lay people are deeply involved. We should employ the AMA organization to inter-relate with the public sector. But if the AMA is to be effective, its man in the street (the individual doctor) will have to speak louder and oftener to officers, delegates and trustees. We again point out that the same doctor can simultaneously communicate with the man he has elected to office in his national government. There must be

interaction and shared responsibility between the public sector, represented by government, and the private sector, represented by organized medicine.

Now is the time for all good medical men to demonstrate that democracy lives. Government and medical socities will necessarily be getting together more and more for negotiations and discussions. It remains to be shown that the doctor, who is the building block of both organizations, will do his whole duty by studying the issues, thinking out his convictions and stating his position and his demands to his elected representatives in medical associations and in various branches of government.

CBL

Occupational Hazards of Physicians

The article, "Occupational Hazards of Physicians—Suicide," by Herbert Freed, M.D. examines a subject that will be read with scrutinizing attention by the physician who seeks a better understanding of himself through the self-analysis that we all engage in to a greater or lesser degree.

Whether or not the reader can place himself within the composite picture of the physician as described in the article as a high suicide risk is less important than facing the problem as it applies to the unique, highly individual self. It is, however, safe to assume that contemplation of the ending of one's own life, at one time or another, occurs to many human beings as he, apart from all other life forms, carries the burden of knowledge that his existence is finite.

Recognization of the increased risk of suicide as an occupational hazard for physicians can be a positive step in reducing the hazard. The high suicide rate among interns as compared with residents tends to suggest a manifestation of emotional instability which goes unrecognized in medical school. While the student with overwhelming problems may be reluctant to seek help out of fear of adversely influencing faculty attitude towards him, medical educators by virtue of their own training and position should be best equipped to recognize and assist more actively the student in resolving his problems.

The suggestion made in the article for using "militant enthusiasm in the service of ethical values" as a possible deterrent measure for older physicians against the use of drugs or alcohol as well as suicide is an attractive alternative for those seeking escape from pathological conflict, anxiety and guilt. This conversion of destructive energy into creative activity can be a useful tool in allowing the physician to utilize his resources.

David A. Smith, M.D.
Associate Editor

Medicine Loses a Friend

State Senator Albert R. Pechan, of Ford City, died on Thursday, September 11, 1969, of a heart attack in Armstrong County General Hospital. With his passing medicine in Pennsylvania loses a very dear friend.

It is in the field of public health legislation that the absence of Senator Pechan will be sorely felt. His interest in this field and his ability to center upon the need for legislation involved him in many a controversy where zeal and courage became his hallmark. The medical profession could always count upon him as an effective ally in the promotion of programs for the common weal.

As Senate majority whip and chairman of the Senate's Committee on Public Health and Welfare for eighteen years Senator Pechan always sought the Pennsylvania Medical Society's thinking with respect to health and welfare legislation. Later this month Senator Pechan was to have managed on the floor two pieces of legislation in which medicine is vitally interested—the so-called Uniform Anatomical Gifts Act and the bill that has passed the House to provide a renal dialysis program in the state. A look at Senator Pechan's record of health care legislation will assure all of the outstanding contributions to public health and welfare.

As chairman of the Senate Public Health and Welfare Committee he was active in the passage of such legislation as medical assistance for the aged; purchase of hospital care; mandatory sentence for peddling narcotics; investigation of the sale of cigarettes for minors from vending machines; and obtaining facilities in public buildings for the convenience of the handicapped.

In addition, Senator Pechan as a member of the Governor's Advisory Committee on Comprehensive Mental Health Planning and the Governor's Hospital Study Commission was extremely important. He played a major role in securing of legislation which embarked the Commonwealth on air pollution control as well as getting special appropriations for the running and maintenance of geriatric centers in the Commonwealth.

In 1966 the Pennsylvania Medical Society presented a special award to Senator Pechan at the Officers' Conference held in Harrisburg. He was a recipient of many awards from voluntary and professional organizations.

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PENNSYLVANIA MEDICINE original papers

Stage O Carcinoma of the Cervix

A Twenty-one Year Survey

JOSEPH A. HEPP, M.D.
Pittsburgh

This study was undertaken to report on the management, age distribution, follow-up and associated malignancies of carcinoma in situ of the cervix. Even though there may still be some differences of opinion among pathologists and clinicians regarding borderline lesions of carcinoma in situ of the cervix, Volume 14 of the Annual Report [1] records eighty institutions reporting 7698 cases of carcinoma in situ from 1951 to 1960 and the ratio between stage O and stage I is 1 : 3. In our study over a twenty-one year period the ratio between stage O and stage I is 1 : 1.8.

Material

This series comprises 367 proven cases of stage O carcinoma seen at Magee-Womens Hospital from 1947 through 1967.

During this same period of time there were 1369 cases of invasive carcinoma of the cervix seen. These invasive carcinomas, as well as stage O, were primarily treated in our institution. The diagnosis of intraepithelial carcinoma was first recognized at Magee-Womens Hospital in 1934. These 367 patients were taken from the records of the attending staff as well as service cases. Over a twenty-one year period 21 per cent of all cases of carcinoma of the cervix were stage O.

Pelvic examination revealed there were 155 patients with an erosion, 139 patients with cervicitis and fifty-five patients in which the cervix was described as clean. Polyp of the cervix was noted in two patients. The Papanicolaou smear is an invaluable aid in the diagnosis of intraepithelial carcinoma; however, it is to be noted that in the early part of our twenty-one year study not all patients were afforded the advantage of this test. Also the method of tissue diagnosis now is cold knife conization but again, early in the study, the diagnosis was made by ring biopsy, selective biopsy with scalpel or punch biopsy. Only sixteen patients were diagnosed by the latter method.

Management

Krieger [2] has described the conservative management of carcinoma in situ by conization. He advises long term follow-up, since carcinoma in situ may develop in the epithelium of the vagina, vulva, urethra and perianal tissue. On the other hand Frick [3] favors a more aggressive approach particularly for women who desire no further pregnancies.

The management of the patients in this series is shown in table I.

Thus, the preferred method of treatment has been total hysterectomy either abdominal or vaginal with a wide cuff and preservation of ovarian tissue in the younger woman. Eighty-nine patients treated by biopsy are being followed with vaginal smears. These patients either refused hysterectomy or were desirous of having more children.

Numerous series comparing the findings of the cone with those of subsequent hysterectomy specimens find a relatively high incidence of residual cancer in situ. Latour [4] reported 28.5 per cent residual tumor in 137 cases. Baker and Hawks [5] reported 27.3 per cent residual tumor in 132 patients. Singleton and Rutledge [6] reported 37.2 per cent of patients with residual carcinoma in situ found in the hysterectomy specimens, after conization of the cervix. In our series, there were 255 who had definitive surgery following prior biopsy and sixty of these patients (23.5 percent) showed residual malignancy in the surgical specimen.

Age Distribution

Comparison of age distribution between stage O and stage I as seen in Table II reveals there were 221 patients between age 17 and 39. This is 60.2 per cent of all in situ cases in the series. The largest number of cases was in the 30-39 year group as noted in Table II. On the other hand, the largest number of stage I cases occurred between age thirty and fifty-nine years. The span between the average age of stage O and stage 1 is 7.0 years.

Follow-Up

Since prolonged follow-up is necessary for all cancer patients, the results of this series can be regarded only as preliminary. The average follow-up period was 8.14 years. This follow-up is shown in Table III.

The range of follow-up was 23 months to 247 months. The total patients involved in the follow-up study was 285. A patient who was treated with x-ray represents the longest survival time, 247 months. On the other hand there is a six and one-half year follow-up with no treatment beyond biopsy due to poor physical

TABLE 1

367 CASES OF CARCINOMA IN SITU OF CERVIX UTERI

MANAGEMENT	NO. PATIENTS
TOTAL ABDOMINAL HYSTERECTOMY	131
VAGINAL HYSTERECTOMY	128
AMPUTATION OF CERVIX STUMP	12
TRACHELECTOMY	2
BIOPSY	89
RADIATION	5

condition. This patient is now 87 years of age.

Associated Malignancies

There were seven patients with a second primary malignant lesion. Four of these patients had simultaneous primary carcinomas. In the other three patients, the second malignancy appeared nine months, thirteen months, and 126 months after the primary carcinoma in situ of the cervix was diagnosed. In all seven patients, the second primary malignancy was confined to the genital tract. Two of these seven patients are dead. This is shown in Table IV.

TABLE II

AGE DISTRIBUTION OF STAGE O AND STAGE I PATIENTS 1947-1967

AGE	STAGE O NUMBER PTS.		STAGE I NUMBER PTS.
Under 20	6		1
20-24	29		3
25-29	43	60.2%	33
30-34	70		50
35-39	73		105
40-44	54		113
45-49	30		77
50-54	19		84
55-59	12		81
60-64	13		41
65-69	10		28
70-74	5		20
75-79	1		5
80-85	2		2
	367		643
	AVERAGE AGE—38.9 YRS. RANGE—17-81 YRS.		AVERAGE AGE—45.9 RANGE—17-83 YRS.

TABLE III

FOLLOW-UP (YEARS)

YEARS	1-3	3-5	5-8	8-11	11-14	14-17	17+	DIED	LOST
NO. PTS.	2	37	95	67	39	9	2	22	12

TABLE IV

ASSOCIATED MALIGNANCIES

AGE	CERVIX	INTERVAL	OTHER SITE	FOLLOW-UP
69	IN SITU	NONE	ENDOMETRIUM—ADENOCARCINOMA	DIED — 17 MONTHS
38	IN SITU	NONE	VAGINA —SQ. CELL CA.	LIVING— 61 MONTHS
34	IN SITU	NONE	VULVA —CA. IN SITU	LIVING— 13 MONTHS
41	IN SITU	NONE	VULVA —CA. IN SITU	LIVING— 62 MONTHS
63	IN SITU	9 MONTHS	VAGINA —CA. IN SITU	LIVING—107 MONTHS
31	IN SITU	13 MONTHS	VULVA —CA. IN SITU	LIVING— 91 MONTHS
37	IN SITU	126 MONTHS	VULVA —SQ. CELL CA.	DIED —143 MONTHS

Summary

The management, age distribution, follow-up, and associated malignancies of 367 patients with carcinoma in situ of the cervix is reported.

Following biopsy and/or conization 23.5 per cent of the patients had residual carcinoma in situ in the surgical specimen.

Over a twenty-one year period 21 per cent of all cases of carcinoma of the cervix were stage O.

There were no adenomatous in situ lesions in this series.

Note: The author is indebted to Mrs. Vida Peterson, Registrar, Tumor Registry, Magee-Womens Hospital, for the statistical analysis of the data.

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Dr. Hepp is professor of clinical gynecology and obstetrics at the University of Pittsburgh School of Medicine and Magee-Womens Hospital. He is a founding member of the American Academy of Obstetrics and Gynecology and a life member of the American College of Surgeons.

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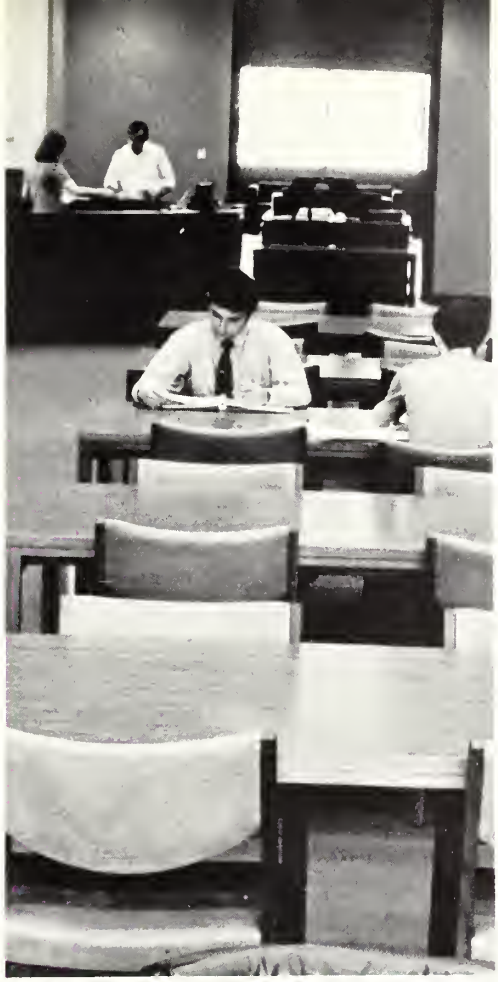

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Further information may be obtained from: Pennsylvania Medical Society, Council on Education and Science, Taylor Bypass and Erford Road, Lemoyne, Pa. 17043.

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October 22	Clarks Summit State Hospital, near Scranton
November 20	Susquehanna Valley Regional Medical Program area, Hershey

Presented by: Mid-Eastern Regional Medical Library Service of the College of Physicians of Philadelphia and the Pennsylvania State Library Division of Institutional Libraries.

Further information may be obtained from: Mrs. Beatrice M. Davis, College of Physicians of Philadelphia, 19 S. 22nd Street, Philadelphia, Pa. 19103.

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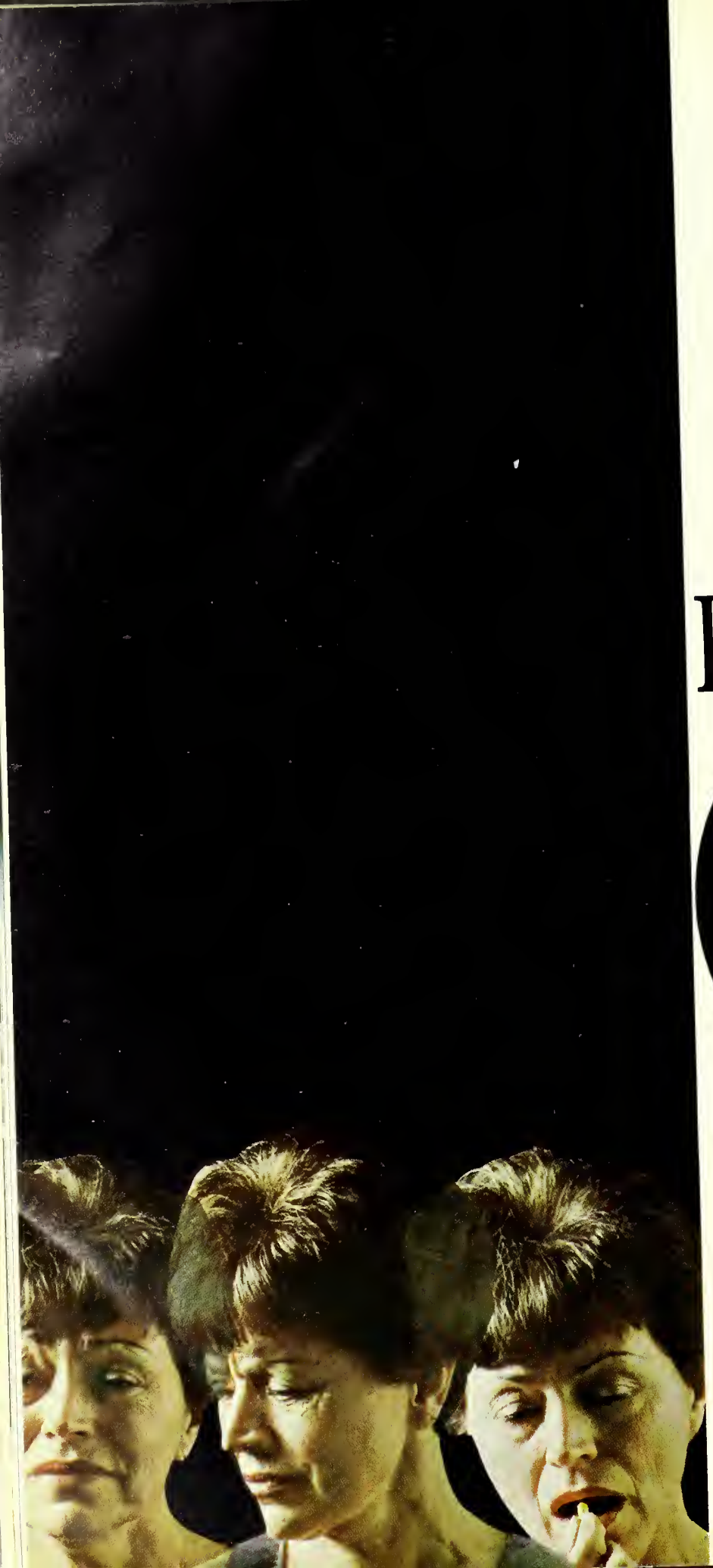
Further information may be obtained from: Mr. Fred D. Bryant, Librarian, The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey, Pa. 17033.



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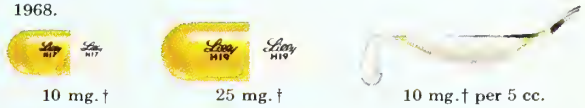
*Mendels, J.: Comparative Trial of Nortriptyline and Amitriptyline in 100 Depressed Patients, Amer. J. Psychiat., *124*:59 (Feb. Supp.), 1968.



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Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two weeks after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl HCl under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Patients receiving a tricyclic antidepressant (e.g., nortriptyline) may respond poorly to hypotensive agents such as guanethidine.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily
10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily
10 mg.—Ages three to six, 1 Pulvule one to three times daily
Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily
Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500. [OB1668A]

Lilly

Additional information available upon request.

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900816

Occupational Hazards of Physicians—Suicide

HERBERT FREED, M.D.
Philadelphia

In the year 1968 two countries which have considered themselves among the most progressive, the United States and Sweden, have established a set of "firsts". In Sweden, the First International Exhibition of Erotic Art was held. The nucleus of the show came from the collection of the American sexologists Phyllis and Eberhard Kronhausen who said that their interest in erotica is part of their concern with mental health: "We feel very strongly that sexuality is the great remaining pocket of cultural insanity." I will not go into the details of the exhibition other than to say that within two days museum-goers, including elderly couples, beatniks and housewives with children had broken all attendance records. In the United States it was not sex but suicide which catalyzed the first National Conference on Suicidology in Chicago and the establishment of a new society, The American Association of Suicidology. It was suggested at the meeting that the suicidologists were reconvening the 1910 Vienna Symposium "On Suicide" at which Sigmund Freud presided. One may disagree with the Kronhausen statement that sexuality is the great remaining pocket of cultural insanity but not with the opinion of suicidologists that suicide may be the last protest against the loss of individual integrity and sanity.

At this conference, Dr. Paul Blackly, of the University of Oregon Medical School, studied the obituaries of the American Medical Association between May, 1965 and November, 1967. He found that suicide caused 249 deaths among physicians. Suicide caused more physician deaths than auto accidents, plane crashes, drownings and homicide combined. Women accounted for 6.5 per cent of the physician suicides but only 3.6 per cent of the total physician deaths. The suicide rate for the interns was double the rate for residents. Dr. Blackly sent out follow up questionnaires to the "next of kin" of the physician suicides. He found that with few exceptions respondents were pleased to help, some apparently using the questionnaire therapeutically as a structure for abreaction and a resynthesis of their own perceptions of the event. He found that none of the physicians was said to have enjoyed good mental health. Seventy-five per cent were listed as either depressed or disturbed. There was insufficient data on the remaining 25 per cent to form an opinion. Significantly 64 per cent of the physicians either had had prior psychiatric treatment or were in treatment at the time of death. Despite this, however, 44 per cent of those who had received therapy were said to have a disdainful pessimistic or negative attitude toward psychiatric treatment as it pertained to them. It should be underlined that "heavy drinking" or alcoholic was recorded for 39 per cent and 19 per cent were drinking at the time of death. Drug dependence or severe abuse was a factor in 19 per cent and only 33 per cent were said not to have used drugs.

Blackly drew a composite picture of the type of physician considered to be a high suicide risk. "The high risk physician is apt to be competitive, compulsive, individualistic, ambitious, a graduate of a high prestige school who had mood swings, a problem with drugs or alcohol and who may feel a lack of restraints by society." This combination of traits may have caused him sufficient anxiety and depression to seek psychiatric help but these are also the very traits which make a worthwhile relationship with a psychiatrist difficult. He is likely to be in a more peripheral branch of medicine often associated with chronic problems where he does not feel useful as an individual.

Since the suicide rate ranges from 10 per 100,000 in pediatricians to 61 per 100,000 among psychiatrists, the marked differences in rate by specialty raises the question as to whether the job influences the susceptibility or whether persons with a particular suicide risk choose the specialty.

Possibly more than any other profession we must deal with the attitudes and emotions which represent the primitive responses that are not necessarily conscious or rational. It is ironical that although the physician should be in the best position to note warnings of an impending suicide threat and thus avert it, the suicide rate among physicians is much higher than that of the general population. One study showed that 26 per cent of all deaths among physicians twenty-five to thirty-nine years of age were suicidal. This compares with a death rate of 9 per cent for white males in the same age group.

It may be said that the physician shares with his culture the taboo of suicide and in so doing may respond to his potentially suicidal patient in a number of ways in accordance with his fearful attitude. The law finds suicide to be criminal; religion treats it as a sin; society shrinks from it and we physicians usually regard it as insanity. But the ambivalence of the distraught doctor or patient may be compounded when one reads in the same year (1965) one authority said, "There is no conceivable human situation which is unendurable or hopeless enough to drive a healthy man to death—neither mental anguish nor concentration camp torture nor pregnancy out of wedlock nor bankruptcy," while a group of psychiatrists wrote, "The impact of a changing state may demand constructive rebellion and the refusal to adapt to unacceptable situations may be the essence of good emotional health; sometimes even death may be if the individual's value system experiences death as a maintenance."

So, we psychiatrists, realizing that we share many common realities, seek with other physicians the prophylactic measures to limit the needless decimation of our ranks. Why should we mouth the statement "Life is for living" and then act as if it is a meaningless cliché for the physician.

Terms such as the doctor's image and charges that he is too prone to be an absent father may be dismissed as clichés because they are heard too often. But it may be unnerving to find out whom your children most admire. The underlying psychological attitudes of the public that the doctor supported by his scientific skills, good judgment and self-reliance should be

omnipotent and omniscient deserve our consideration. Too often he finds it difficult to ever appear uncertain or inadequate. He relies on his wife to conceal his defects from his children. He depends on his whole family to preserve that image held by his patients that he is as conscientious as our vanishing country practitioner was. Unfortunately, instead of seeing himself as courageous and sagacious, too often he sees himself as affluent and afflicted. Both his family and his patients may complain of his lack of interest. His wife observes that he never seemed to realize how tired he was until they settled down for a nice long talk. The threat of depression and the weight of fatigue hang over him. They mount with patient overload. They nudge him every moment that his perfectionistic trends compensate for difficult patients and diagnostic dilemmas. The appeal of available drugs for self medication is often overwhelming.

These comments about the doctor's image and the demands made of him are offered as constructive criticism. I fully realize that few want constructive criticism; it's all we can do to put up with constructive praise. Too often ideals are for us like nagging wives, always tormenting us for our own good.

Earlier Blackly drew a composite picture of the type of physician considered to be a high suicide risk. Can we learn something from the recent study of forty physicians hospitalized for acute psychiatric conditions and then followed up for three to fifteen years? Over half are now in active practice and found it necessary to alter their personal and professional lives to reduce stress and strain. It was noted that they had been individuals who were lacking in recreational interests and outside interpersonal relationships.

A psychiatrist had been defined as a man who has been trained to understand and explain to other people the facts of life—which he himself has to avoid in order to become a psychiatrist. Let me speak from this base for a moment about the avoidance of unjustified hostility and guilt which is the forerunner of depression and the usual antecedent of suicide. An essential is the cultivation of communication with those closest to you and with the inner self. "What" you may ask, "should you go around talking to yourself?" Not ordinarily, but there is a suggestion—on stressful occasions where you must master strong feelings or mull over a disturbing unsettled problem—try talking into your tape recorder and then listening to yourself. The manner in which you pour it out as well as the content may give you both new insights and quicker solutions. It is worthwhile to utilize what can be called a spiritual tape recorder while you engage in that degree of introspection which does not degenerate into rumination. Introspection is not easily come by these days. Television and radio, travel and taxes, fatherhood and motherhood fractionate what we would consider suitable leisure time. Leisure has been described as society's blotting paper. But for us introspection and leisure are precious commodities. Leisure can be used to fight against despair and not just to forget despair. (Leisure can be the place and time where we choose real difficulties for ourselves to be overcome by ourselves.)

As physicians our goals are the better control of those biological mechanisms—pain, anxiety and guilt. We are justly proud of our achievement with pain. The mountains of tranquilizers have melted some anxieties but the challenge remains as long as pathological guilt is still our biggest psychological burden. It would seem that primitive man discovered alcohol and modern man defined its function. He observed that the superego, our conscience, our guilt factory, is soluble in alcohol. This solvent is too readily available for us as are other medicines. Too often they become the road to self-medication and self-deceit. It's so hard to resist sermonizing particularly about middle age—the time when you'll do anything to feel better except give up what is hurting you—the time when you can do just as much as ever, but would rather not.

So let me close on a more positive note. Lorenz and other ethologists, those who study the developmental psychology of animals and relate it to human behavior, suggest that with aggression (which Freud tied up with guilt and suicide) we have also evolved a form of behavior today which could be used as a cultural life saver. He calls it "militant enthusiasm." Enthusiasm is that quality we oldsters envy so much in youth. The Greeks implied that a man showed it when he was possessed by God. The adjective "militant" today has mixed connotations. For Lorenz —militant enthusiasm is a specialized form of communal aggression which every man of strong emotion knows. He observed that such a man shows the stiffened carriage, the arms raised from the sides and slightly rotated inward so that the elbows point outward, the chin sticks out with the head raised and on the back and along the outer surface of the arms the hair stands on end. I would suggest that we might be inspired by the phenomenon we observed recently—the enthusiasm of the many youthful followers of Senator McCarthy. Many explanations can be offered for it. Could it be that Lorenz gave us a biological basis for it? Lorenz adds that anybody who has ever seen the corresponding behavior of the male chimpanzee defending his band or family with self sacrificing courage will doubt the purely spiritual character of human enthusiasm. The chimp too sticks out his chin, stiffens his body, raises his elbows and his hair stands on end. Besides Lorenz, Desmond Morris the biologist has reminded us in his best seller that we are but naked apes. Indeed Masters and Johnson have goaded us also. They have clinical and biological evidence—both you and your wife can enjoy a fuller sex life for a longer span of years. We must make it possible to recruit militant enthusiasm in the service of ethical as well as psychosexual values. Let us use to the fullest our biological potentials.

Dr. Freed is clinical professor of psychiatry at Temple University School of Medicine and a lecturer at the Philadelphia Psychoanalytic Institute. He is the author of more than sixty papers published on psychiatric subjects and received the Philadelphia County Medical Society's annual Da Costa award for an oration delivered in 1963.

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SOCIO ECONOMIC SEMINAR

2:00 PM

COMPREHENSIVE HEALTH PLANNING

WILLIAM J. PUTNAM, D.D.S., Assistant Surgeon General, Regional Health Director, Department of H.E.W., Region II

THOMAS W. GEORGES, JR., M.D., Secretary of Health, Commonwealth of Pennsylvania

MATTHEW MARSHALL, JR., M.D., Chairman, PMS Council on Medical Service

JOHN L. STEIGERWALT, M.D., Regional Comprehensive Health Planning Agency for S.E. Pennsylvania

3:30 PM

PROFESSIONAL CORPORATIONS

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FRIDAY - OCTOBER 10
DELAWARE BALLROOM
MARRIOTT MOTOR HOTEL
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PENNSYLVANIA MEDICINE correspondence

On Doctors and Title XIX

August 28, 1969

The Honorable Robert H. Finch, Secretary
Department of Health, Education and Welfare
Room 5246
North Office Building
330 Independence Avenue S.W.
Washington, D. C. 20201

Dear Mr. Secretary:

If your August 15 letter to Senator Abraham D. Ribicoff has been quoted accurately in the national wire service articles that came to our attention this week, it contains one statement with which we agree wholeheartedly and some statements that are grossly misleading, especially if one applies them to Pennsylvania.

We can best measure the comments attributed to you in light of the situation in Pennsylvania where several of the statements are at variance with the facts. Here is a brief discussion of them, and we would be glad to supply you with the record of written documents that pertain to our discussion:

You are quoted as saying that the medical profession should—but fails to—help police the Title XIX (Medicaid) program; that the profession should be "watchdogs of cost and guardians of quality."

The Pennsylvania Medical Society is a national leader in the establishment of effective utilization and review committees and we have sought—unsuccessfully—to have that concept applied to the Title XIX program ever since it was implemented on January 1, 1966, in Pennsylvania. Instead of failing to police the program, we have continually suggested that we be allowed to do so but to date our review committees have not received a request from our Department of Public Welfare to review cases. In related action, we have been urging—for several years—that the Commonwealth designate Pennsylvania Blue Shield as the fiscal agent for the physician payment portion of Title XIX because Blue Shield has the experience and expertise to audit the program effectively.

If there is a question about our effectiveness as "watchdogs:" we have been involved in utilization review programs for the past ten years, and have provided satisfactory results for Blue Cross, Blue Shield, commercial carriers and labor.

The second point which we find disturbing is the often made one that "doctors generate the bulk of Medicaid expenditures." Certainly they do, but to use the same semantical barb we could say with equal fervor that rescue and relief agencies generate the major cost of a disaster. We think the analogy is pertinent. Rescue and relief agencies exist to cope with, for instance, a hurricane Camille. Physicians exist to cope with accidents and disease. We submit that accidents and disease generate the bulk of Medicaid expenditures in the same way that disaster generates the cost of rescue and relief work. Relief workers and the physicians both use the skills, tools and mechanisms developed to fight their particular foes and the price tags on those skills, tools and mechanisms generally are established in the market place by others than those who use them.

To place physician costs in the Medicaid program in perspective, latest available data from the Pennsylvania Department of Public Welfare show that payments to medical doctors and osteopaths in Pennsylvania represent less than 9 per cent of the Title XIX health care dollar. What various federal spokesmen have generated could be aptly defined as a growing physician frustration over being blamed for the cost of hospitalization when the patient's condition requires hospitalization, and over being blamed for the cost of drugs when the drugs are necessary to fight disease or to alleviate suffering. We wish we had an effective way to control the daily cost of hospitalization but forces beyond the control of the physician are at work in the health care field. Not the least of these is the general inflationary spiral. However, in a discussion of costs we are well aware that it is impractical to relate today's health care price tag to the cost of yesterday because they are not for the same products. A big chunk of the increased cost is attributable directly to the increased quality of health care.

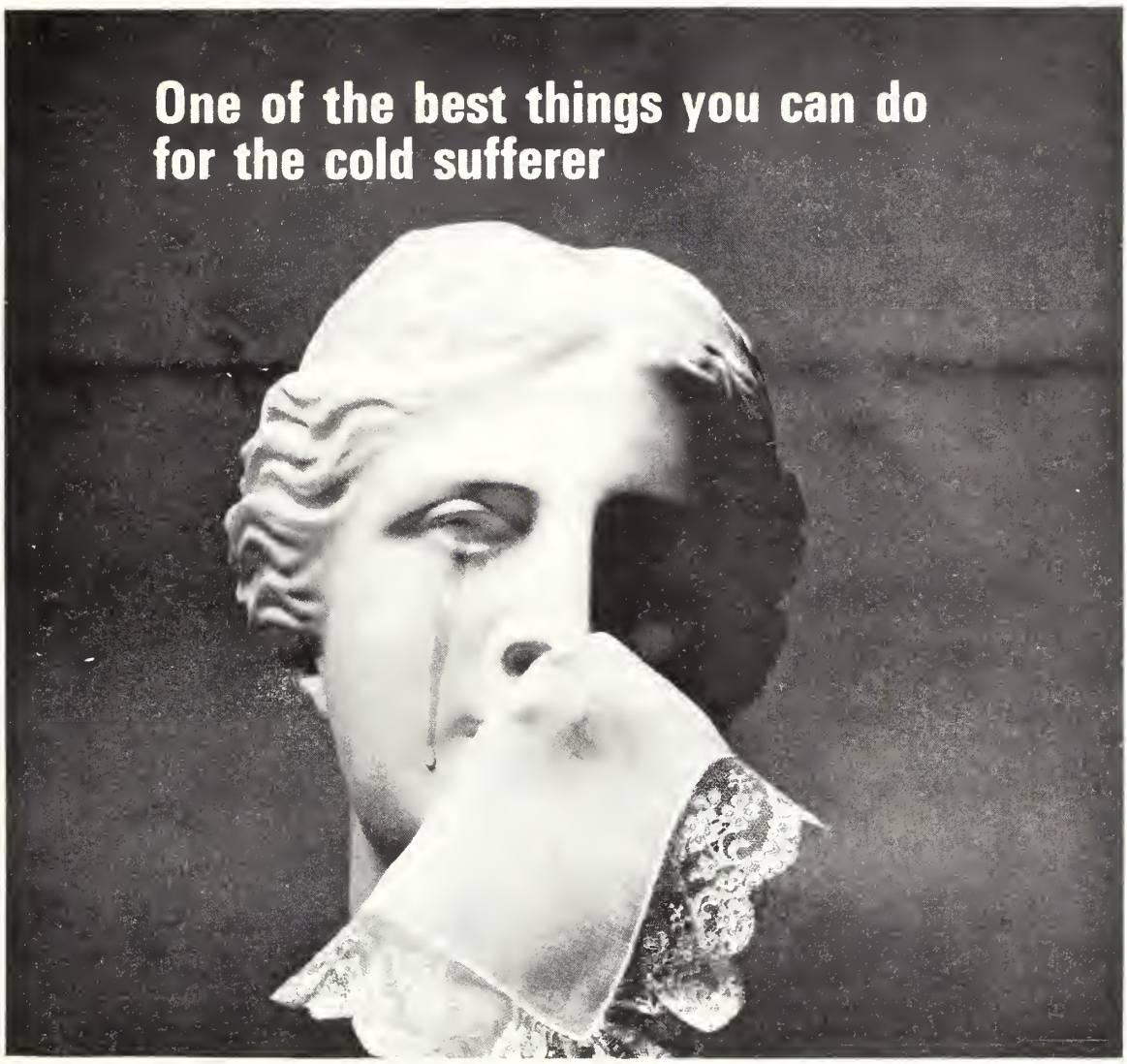
We agree completely with at least one of the statements attributed to you. As quoted, it is your suggestion that state Medicaid directors work more closely with state medical societies and their medical advisory committees to encourage more physician involvement in controlling costs. As we mentioned earlier, we have been suggesting precisely that for more than three years and if there is anything that you can do to implement your suggestion, you will find us eager, and I believe, able to perform effectively.

I doubt that the Pennsylvania Medical Society is unique. Many other state medical societies must be as willing and as able as we are to do that which you suggest should we be but given the opportunity.

I doubt that there is any great difference between your goals and the goals of the Pennsylvania Medical Society. Certainly our major goals would be realized sooner if we have the opportunity to work together and use that opportunity constructively rather than as a forum for divisive criticism.

In view of that, we reiterate our continued willingness to do all that we can to make the best quality medical care easily available and desirable to all persons at a reasonable cost.

Sincerely yours,
George E. Farrar, Jr., M.D., President
Pennsylvania Medical Society



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Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth, nervousness, insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
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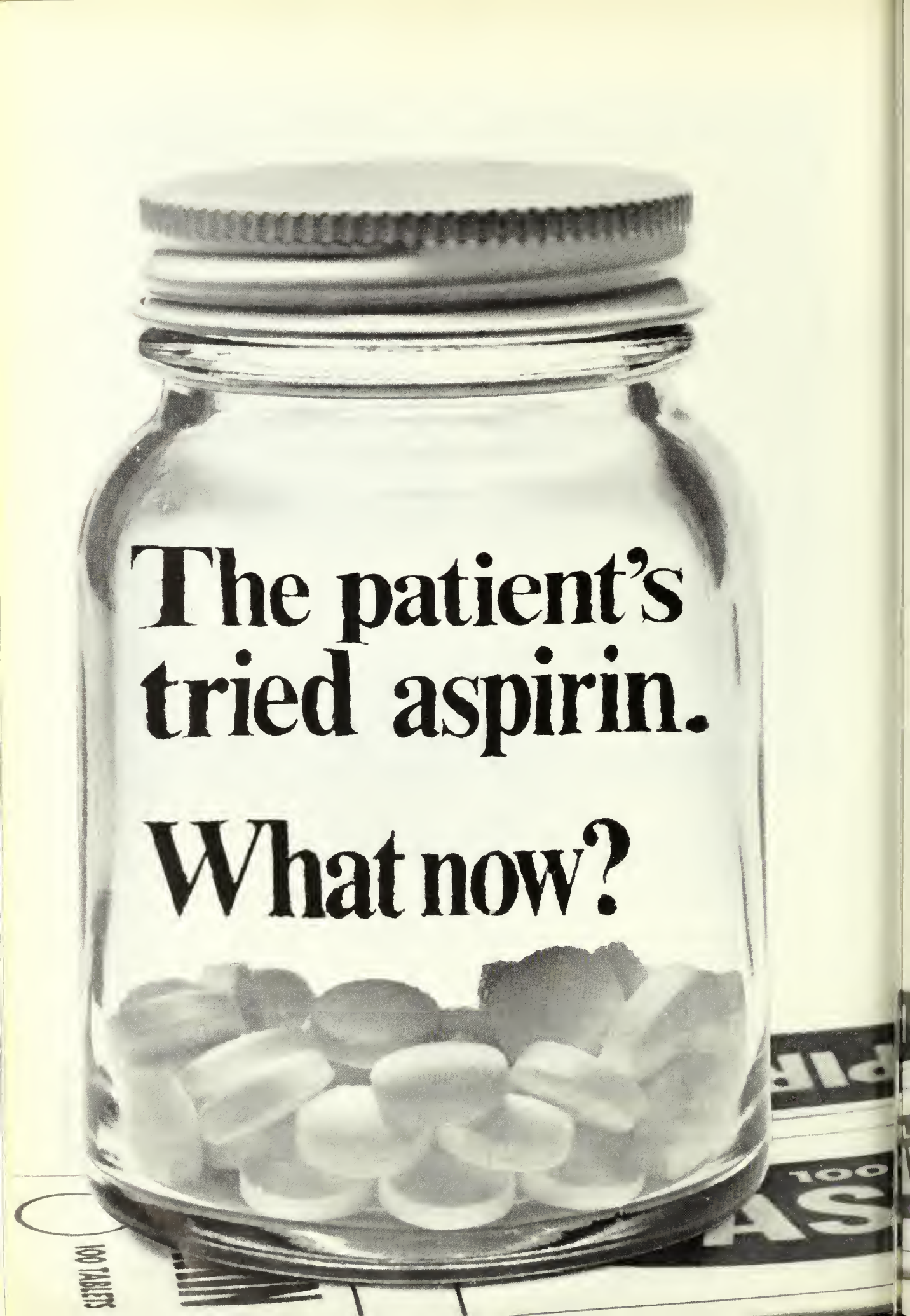
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IN BRIEF

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Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

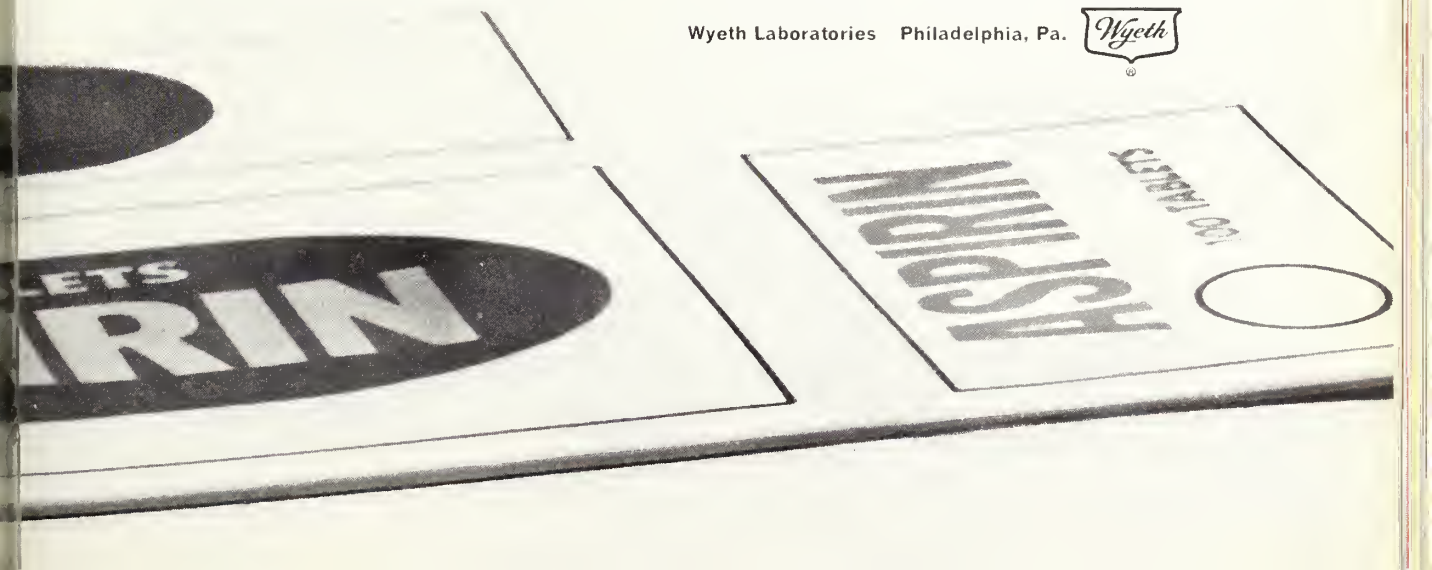
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



The Coronary Care Unit and Arrhythmias Complicating Myocardial Infarction

Part I

■ **Irving Imber, M.D., Senior Physician, Reading Hospital, Reading, is questioned by William G. Leaman, Jr., M.D.**

What is the purpose of the Coronary Care Unit?

The main purpose of the coronary intensive care unit is the early detection of rhythm changes which are the major hazard of acute myocardial infarction. For many decades it has been recognized that sudden death has often been preceded by an arrhythmia. Continuous electrocardiographic monitoring introduced in the early 1960's revealed that arrhythmias in acute myocardial infarction were more common than suspected. Thus, prompt use of drugs, external cardiac massage, electrical defibrillation, or implantation of a pacemaker, may be life-saving.

Which patients should be placed in the coronary care unit?

All patients with proved or suspected acute myocardial infarction are admitted to the coronary care unit during the first five days when the incidence of arrhythmias is the highest. Differential diagnosis initially may be quite difficult. Therefore, suspected coronary occlusion patients should have the benefit of this unit until the diagnosis is established.

What is the key to the success of the coronary care unit?

The staff is the hallmark of the unit. Continuous monitoring, observation and readiness to institute emergency treatment are essential. Many satisfactory monitoring units are available, but the one supplying the best equipment service in the area is probably the best. It is usually possible to staff the unit with nurses especially trained to recognize, diagnose and report to the physicians transitory arrhythmias.

Are there patients with myocardial infarction who should not be in the unit?

All patients with a heart attack will not be admitted to the hospital. If the history suggests that the occlusion has occurred a few days prior to entry and the course has been uneventful, the coronary care unit is probably unnecessary. Also, if the patient is particularly anxious and the unit procedure produces apprehension, the facility is contraindicated. In patients in cardiogenic shock and failure, the occurrence of a serious arrhythmia is uniformly fatal so that the use of the unit is debatable.

What are the arrhythmias which are encountered as a result of a fresh myocardial infarction?

Arrhythmias may be divided into: (1) supraventricular arrhythmias, (2) ventricular arrhythmias and (3) heart block. The *supraventricular arrhythmias* are often transient. Atrial and nodal premature beats may herald more severe atrial arrhythmias. Paroxysmal atrial or nodal tachycardias may be troublesome but are uncommon. Atrial flutter and fibrillation require careful attention, and sinus bradycardia may herald more serious arrhythmias. Sinus tachycardia is a normal circulatory response to many stimuli and other underlying diseases must be sought. Paroxysmal atrial tachycardia and atrioventricular block may occur spontaneously in the absence of digitalis or potassium depletion.

Ventricular arrhythmias are the most commonly seen. The majority of patients have ventricular premature beats. When these are frequent and multifocal, or fall on the T-Wave of the previous normally-conducted beat, they may indicate the onset of ventricular tachycardia or fibrillation. Ventricular tachycardia may occur in two forms: brief bursts of six to eight beats are often seen and do not cause as much concern as the prolonged unremitting type of ventricular tachycardia with a rate of 140 to 160, which is life threatening. The sudden onset of ventricular flutter or fibrillation is a common cause of death and requires immediate therapy. When ventricular asystole (standstill) occurs, it may be temporary or persistent.

The occurrence of *heart block* may be an ominous sign. First degree heart block or prolonged P-R Interval is common, but if a high degree of A-V block develops, closer supervision is indicated. When second degree block develops, one must be concerned about the progression to third degree or complete heart block.

Treatment of all forms of arrhythmias will be discussed in part II of this Brief.

■ **William G. Leaman, Jr., M.D., edited this brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.**

Let's be specific about Campbell's Soups... and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

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Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

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Campbell Soup Company, Box 265, Camden, N. J. 08101

Pro-Banthine® Helps...

propantheline bromide

...REVEAL the ulcer

...HEAL the ulcer

The efficiency of Pro-Banthine—its favorable balance of therapeutic and secondary actions—has been thoroughly tested and observed. This quality has been demonstrated surgically, roentgenographically, cinegastroscopically and, above all, clinically.

When physicians needed to relax the restless duodenum for the recently refined technic of hypotonic duodenography they logically turned to Pro-Banthine.

For years Pro-Banthine has been the most widely used anticholinergic medication for calming the gastrointestinal tract—for suppressing secretion, prolonging the action of antacids and providing the proper environment for healing peptic ulcers.

These established therapeutic actions make Pro-Banthine particularly useful in:

- peptic ulcer
- gastritis
- diverticulitis
- irritable colon
- biliary dyskinesia
- functional hypermotility

We wish to thank Drs. Marcia K. Bilbao, Louis H. Frische, Josef Rösch and Charles T. Dotter for this exceptionally graphic example of hypotonic duodenography.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

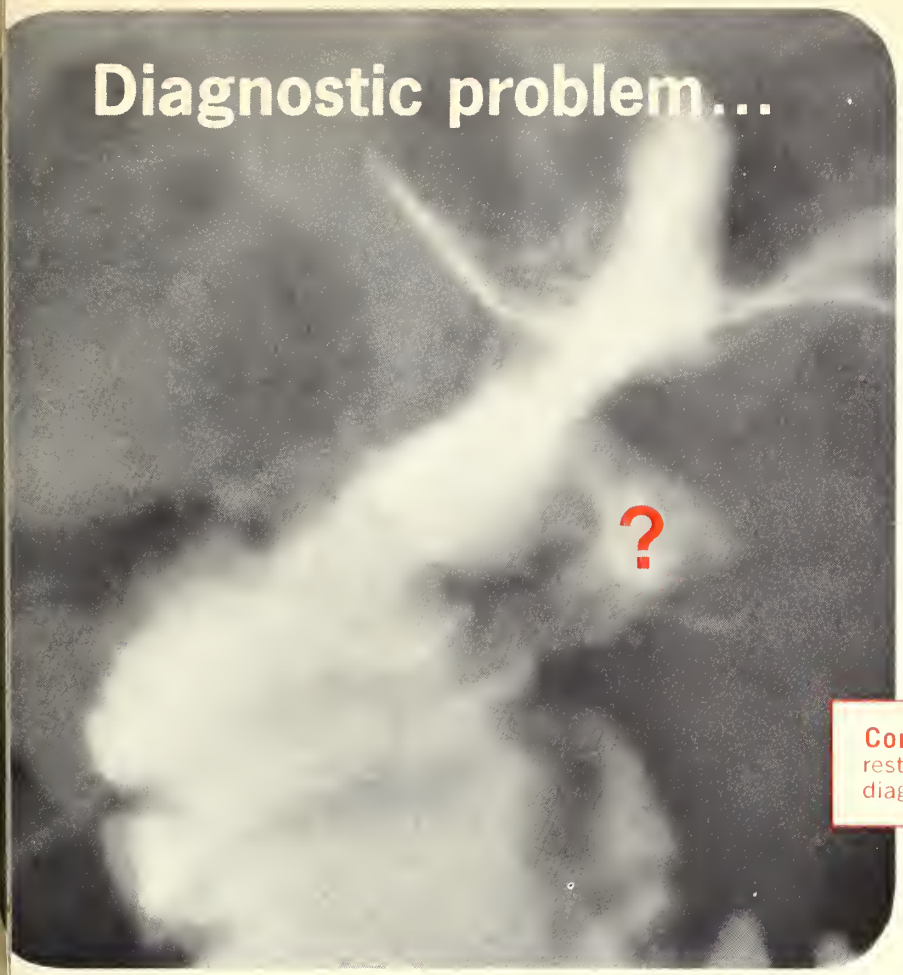
Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal dosage tolerated without excessive side effects is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two 15-mg. tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

982

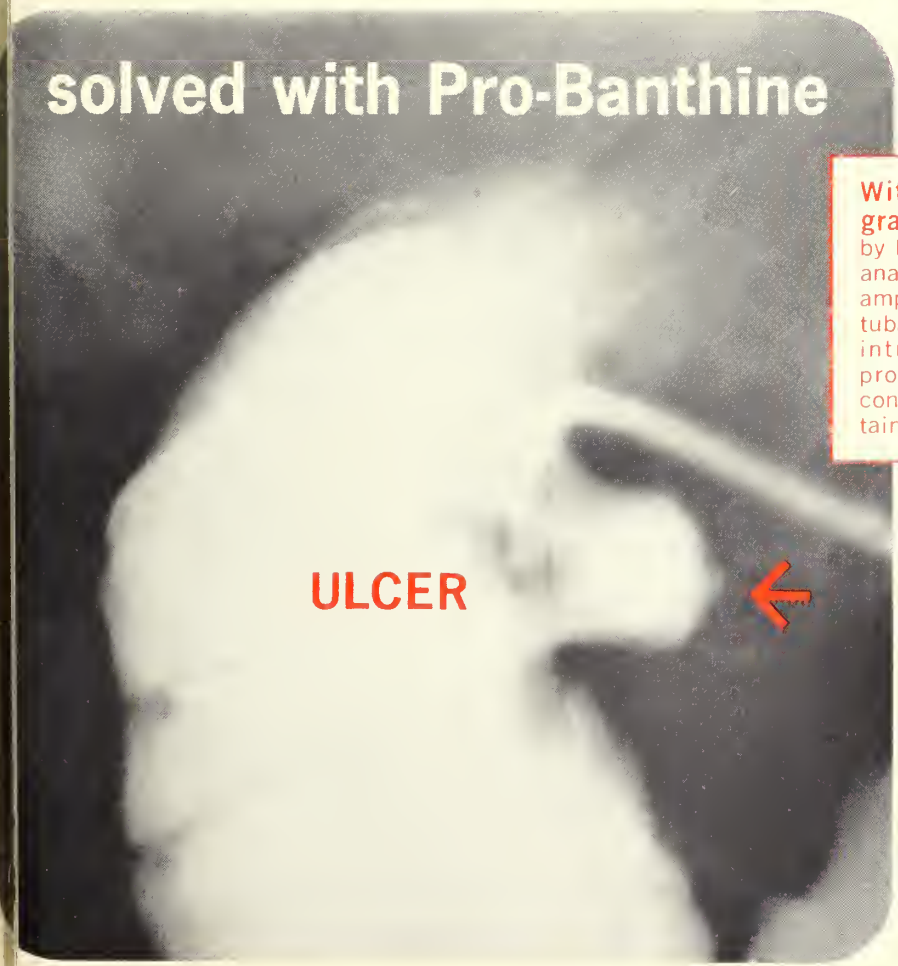
SEARLE *Research in the Service of Medicine*

Diagnostic problem...



Conventional x-rays of the restless duodenum are often diagnostically indefinite.

solved with Pro-Banthine



With hypotonic duodenography duodenal calm induced by Pro-Banthine permits clear anatomic appraisal. In this example the duodenum was intubated. Pro-Banthine, 60 mg. intramuscularly, produced prompt aperistalsis. Double contrast visualization was obtained with barium and air.

What's Polycillin® (ampicillin trihydrate) got to do with the price of bananas?

Just this: According to the U.S. Bureau of Labor Statistics, bananas are one of the few things that actually cost less today than five years ago. The same is true of Polycillin. In fact, the price of Polycillin has been reduced about 30% since its introduction in 1963...making it, according to national surveys of patient costs, as economical as leading brands of tetracycline and erythromycin.

And Polycillin is available in a variety of dosage forms for your patients—more than any other ampicillin. It comes in 250 mg. and 500 mg. capsules; in convenient, chewable tablets of 125 mg; oral suspension, 125 mg. and 250 mg. per 5 ml.; and in pediatric drops, 100 mg. per ml. Also available parenterally as Polycillin-N (sodium ampicillin).

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

Reach To Recovery Program—Part I

The Reach to Recovery Program is a rehabilitation program for women who have had radical breast surgery. It was developed by the Reach to Recovery Foundation, a voluntary, nonprofit organization—but is now a part of the American Cancer Society.

Reach to Recovery is conducted by carefully selected and trained volunteers who have had breast surgery. It is planned to help the patient achieve maximum recovery, physically, psychologically, and cosmetically.

Medical personnel are relieved of many time-consuming activities, which are not primarily medical in nature but are most important to the total recovery of the patient. The mastectomy patient is able to see and talk to another woman who has had the same surgery. She sees living, visual proof that it will be possible for her to look normal and to assume her normal activities. She receives practical help on how to go about doing it.

The Reach to Recovery Program requires strict adherence to its procedures by all volunteers working with patients. The hospital volunteer program is carried out only with the knowledge and consent of a physician or surgeon and at no time is a patient visited in the hospital unless such consent has been obtained. Only a woman who has herself undergone a mastectomy may work with patients. In addition, two doctors must certify that in their opinion she is physically and emotionally equipped to participate in the program. The volunteer, once approved, is thoroughly trained in procedures for visiting patients and particularly in what not to say. The importance of her whole manner and appearance is stressed in her training.

Upon visiting a patient, the volunteer provides a gift of a Reach to Recovery Kit. The kit contains a Reach to Recovery Manual (information for the patient and her family), a ball and rope for exercises, and a temporary prosthesis for the patient to wear when leaving the hospital. The volunteer gives information on exercises, suggestions for brassiere comfort and clothing adjustments, and explanations of the various prosthesis. She also answers questions the patient may have of a non-medical nature. Volunteers never make comparisons or answer medical questions. They do recommend that the patient discuss such matters with her own physician.

Next month's Cancer Forum will conclude our discussion of the American Cancer Society Reach to Recovery Program.

Report of the Acting Chairman

STATE BOARD OF MEDICAL EDUCATION AND LICENSURE

The following report was delivered to the Board of Trustees and Councilors of the Pennsylvania Medical Society at its meeting at Society headquarters in Lemoyne, Wednesday, August 13, 1969, by John F. Hartman, Jr., M.D., acting chairman of the State Board of Medical Education and Licensure.

It has been my pleasure to attend board meetings in the capacity of a representative of a Council of this State Society. Now I find myself in the interesting position of representing the State Board of Medical Education and Licensure.

I have a few facts and figures—I abhor statistics—but I want to pass a few of them on to you to give you an idea of what the Medical Board does.

In 1968, medical examinations (including sixty-nine oral) were given to 385 candidates who received licenses; and by endorsement 745, for a total number of licenses issued in 1968 to physicians of 1,130.

Additionally, we also licensed physical therapists. There were 88 of those for a total number of 1,218 licenses issued in 1968.

We certified out of state 555 physicians who received from our license in Pennsylvania a license in another state. There were 111 postgraduate certificates issued. These are certificates that are issued primarily to American graduates who have a license in another state to do residency work in this state.

There were 879 foreign postgraduate registration forms issued. These were both new and renewal.

In the two-year period of 1967-68, renewal licenses amounted to 23,596. This, to me, is a very interesting figure. If there are that many physicians licensed in Pennsylvania, it obviously means there are a number of physicians who do not reside or practice in Pennsylvania who still maintain their licensure here.

There are 1,302 who have their physical therapy license. Also, on an annual basis, there were 54 midwives who had their licenses renewed and there were 122 postgraduate licenses issued.

In 1968, our board held nine meetings; we had two written examinations; there was one formal hearing and five automatic suspensions. The automatic suspensions were to individuals who were committed to an institution for various causes.

In 1969, at our May examinations in Philadelphia, there were 224 candidates in medicine and surgery. Thirteen failed for a 6 per cent failure rate. There were eight candidates for physical therapy with one failure. One candidate sat in a midwives' examination and she was very successful. I happened to be one of those who marked her paper and we had to find some reason not to give her 100 on her examination. She wrote a beautiful paper.

The 1969 record of new licenses issued since January 1 to date are 384; licenses by endorsement—612; for a total of 996 that have been issued so far this year.

Our board in 1969 has approved six osteopaths for residency training in Pennsylvania hospitals and four osteopaths for internship.

The Pennsylvania board will recognize FLEX examination endorsements if they are conducted by another state. We will give them a license by endorsement. It is the feeling of the board at the moment that we have no objections to the FLEX examination but they are very expensive and we are so far satisfied with our PBX examinations which we get from a professional examination service in New York.

The biennial registrations from January 1 this year to December 31, 1970, so far show that there have been 23,081 doctors who have renewed their licenses in Pennsylvania. There are a number of others. I have a list of figures of fees that are charged for the various examinations, endorsements and so on that I can give to you if you want.

There is an interesting figure I would like to give you. The last annual report we have of fiscal status in the Commonwealth is 1967. We have not received a 1968 report yet of the fees collected by the State Board of Medical Education and Licensure which go into the General Fund of the Treasury Department. Our board was responsible for submitting $315,606 in 1967.

The expenditures by the medical board in 1967 were $61,615. In other words, the cost of running the medical board in 1967 was about one-fifth of the amount of money that we put into the general treasury. There is only one other state board which puts more money into this fund than we do and that is the Board of Nurse Examiners. Of course, there are about 100,000 registered nurses in the state and they put about $200,000 more into the General Fund than we do.

We had a meeting with the Joint State Commission Task Force in January of this year concerning the licensing of paramedical groups. It was a very interesting meeting.

Right in the middle of a sentence, the chairman kind of excused us and she as much as said: "Don't call us, we'll call you." We have heard nothing from her since. I heard through the grapevine just today from one of our staff members that this Joint Commission is about to come out with a report. It is rumored that they may recommend licensing of some paramedical groups. Time will tell.

To show some of the work by our credentials evaluator, Colonel Alton Arnold, from the first of January to date—he has had 1,085 interviews with physicians in Philadelphia and Pittsburgh. This figure does not include interviews that have been conducted in our board office or by board members. You might be interested to know that our board over the past few years has given a license to candidates who passed a written examination to fourteen osteopaths who had one of those honorary M.D. degrees from the State of California. They took our written examination, passed it, and we gave them a license.

That concludes my report, Mr. Chairman.

ATTENTION GETTER!

BENJAMIN RUSH AWARDS PROGRAM

Look around at the favorable publicity county medical societies received last year simply for presenting Benjamin Rush Awards

Public relationswise, the value of the Rush Awards program is tremendous. Not to be forgotten, of course, is the fact that it provides deserving recognition to individuals and groups for their voluntary health efforts.

If you want an attention getter for your county medical society, plan your Rush Award program early. Send a post card to the PMS Council on Public Service for a comprehensive program kit.

Medical Society Seeks

Candy Striper and H. A. M Get Rush A

Rush Award Given Area Man For Aid To Mental Patients

Rush Award Recipien Are Cho

Candidates for Rush Award are Requested

Society To Present Plaques

Benjamin Rush Nominations Are S

Medical Unit Makes Awards

Shippensb'g Woman, CCARC Get Honors

Volunteer, Sisterhood Unit Get Benjamin Rush Awards

Medical Award Entries Sought

County Unit Will Pay Recognition

Recipients Of Rush Awards In County

Benjamin Rush Award Given Mrs. Goodhart

Medical Society Seeks Nominees

Benjamin Rush Awards Slated for School, Woma

Rush Award to Mother of Local Woman

Volunteer, Sisterhood Unit Get Benjamin Rush Awards

Continued from Page 5

Medicol Society Honors Nurse

Pertofrane® desipramine hydrochloride

Indication: Mental depression.

Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal.

When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants.

Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm.

Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold).

Desipramine and the parent compound, imipramine, have been shown to block the action of guanethidine and related adrenergic neuron-blocking agents.

Hypertensive episodes have been observed during surgery.

The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures.

Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery.

Do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk, and do not use in patients under 12 years of age.

Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients.

Precautions: Potentially suicidal patients require careful supervision and protective measures during therapy. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement.

Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents).

Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances.

Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy.

Adverse Reactions: The following have been reported. *Nervous System*: dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract*: anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin*: skin rashes (including photosensitization), perspiration and flushing sensations. *Liver*: rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements*: bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System*: orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System*: urinary frequency or retention and impotence. *Endocrine System*: occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity*: urticaria and rare instances of drug fever and cross sensitivity with imipramine.

Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily.

Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response.

Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated.

Availability: Maroon and pink capsules of 50 mg. in bottles of 100; pink capsules of 25 mg. in bottles of 100 and 1000. (B)46-530-G

For complete details, please see the full prescribing information.

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Division of Geigy Chemical Corporation
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Coming out of a depression.

And it can often begin to happen in 3 to 5 days with an antidepressant like Pertofrane. There's a lifting of depressed mood... a restoration of psychomotor activity. Patients usually begin to cope, work, maybe play, even enjoy.

It's not all beautiful. Sometimes there are side effects. And not everybody can take the drug. It may even be a slow process. But along with the care and comfort you give depressed patients, consider Pertofrane. Then consider the response.

Please read the prescribing information for full details on contraindications, warnings, precautions, adverse reactions and dosage. It's summarized on the left.

Pertofrane®

desipramine hydrochloride

New 50-mg. capsules now available.

It's beautiful!

Homage to Lester Perry

Retirement has many meanings, but, as is so often the case, they are ignored by the majority of people. The unthoughtful assume that arrival at the age to leave off regular work brings the same effect to bear in every case. In truth, however, retirement is what the one who retires can make of it. As in all of life, the meaning and value vary with the stature of the protagonist in the action.

When suddenly confronted with the fact that Les Perry is to retire from his labors as executive director of the Pennsylvania Medical Society, his many fellow workers may have been expected to feel some sinking of the spirit—some feeling that this must not be and that things can never go on as before. But to those who have worked long with Mr. Perry, such misgivings will be short lived. They will have learned that the edifice which has been the life work of our executive director is a stable one, built upon sound principles and practices.

We can count on the fact that Mr. Perry's own life will go on with the high degree of productivity, to which we have all become accustomed. The tempo may change but it is inconceivable that there will be a sudden cessation of the output of useful human accomplishment which has characterized Mr. Perry's life. We need have no further worry about this.

In considering the future of the Pennsylvania Medical Society, deprived of the guidance and leadership of its chief executive officer of many years, I propose to say much more. From time to time it has been my privilege and opportunity to point out to the members of our State Society one or another of their hidden assets. It has been my pleasure to be able to tell my fellow physicians that the State Society structure contains many silent, on-going activities which are of great benefit to them but which are largely or entirely ignored by the busy practitioner.

Such assets are of course actually the products of the work of the people who make up the core of the State Society—the officers, the physicians who serve on councils, commissions and committees, and, least noticed of all, the fine men and women who make up the professional staff at the State Society's headquarters in Lemoyne.

And now I add the final line to these editorial writings which have tried to bring light upon our hidden assets. In large measure these valuable possessions of the doctors of Pennsylvania ultimately stem from the planning and implementation of our executive director whose "fine Italian hand" remains concealed when the reports are published.

Let us give some thought to just what Lester Perry has been to the doctors of our Commonwealth, and let us examine my statement that his organization is built to endure and to continue to be efficient and productive in the service of organized medicine in our state.

First of all, Mr. Perry is a manager—an up-to-date type of manager who knows his business and can employ its assets of personnel and other resources to achieve its goals. In his capacity as manager he has never failed to act as the leader of a complex organization. But he has never, to my knowledge, acted as a manager in the older entrepreneurial sense of singlehanded, dictatorial

enforcement of personal convictions as to policy. Those who know him best feel that his modern management of our resources of people, financial assets, property and background constitute his outstanding qualification.

Secondly, Mr. Perry is a specialist in medical society affairs. Coming to us in the mid-thirties from the field of college teaching, our executive director has had a long and carefully planned career of learning his business—the management of a medical association. Those early years were of tremendous value to him and to us. They made it possible for us to enter the modern era of medical specialization, of hospital centered medical practice and the like, with confidence in the knowledge of what doctors should get from their medical society and how they should be guided in obtaining it.

Perhaps the greatest field of Mr. Perry's expertise lies in the area of *personnel*. At all times, to my knowledge, he has succeeded in surrounding himself with a splendid staff of men and women. His staff was always equipped and ready to accomplish those goals of organized medicine which were laid before them.

Not the smallest problem in accomplishing such a task is the complexity of working with a large and varied group of physicians. "Doctors are individualists" is a commonly heard statement. It is certainly true but is stated in a very kindly way; one could also say that they are likely to be extremists, prima donnas, enthusiasts, or many other things. Whatever they were when they worked for the State Society, their individual talents seemed to be efficiently channeled into the stream of activity, and the program of the Pennsylvania Medical Society was enhanced.

Mr. Perry's relationships with his fellow executives of medical societies at county, state and national levels have proved to be similarly advantageous for the accomplishment of our ends. His ready acceptance in this relatively small circle has made it easily possible to carry out those parts of our program which depend upon working together with other units of Organized Medicine.

Not the least of Mr. Perry's abilities arises from the fact that, in essence, he was trained as a communicator. He is very well able to put across the ideas which he effectively formulates. He expresses these in so plain and forceful a way that the carrying out of the project in hand is greatly speeded up and materially simplified.

Managing and accounting for the finances of the Society is an important aspect of the work of our staff. I am not aware of the source of our executive director's skills in this field and must content myself with stating that, somewhere along the line of his career he found time and strength to learn how to keep a sharp eye on your dues dollar—how to keep track of it as well as how best to make use of it. This makes up a large part of our indebtedness for his services.

An interesting and instructive aspect of Mr. Perry's program is his employment of outside experts to counsel and guide the Society in certain specialized fields. For example, management consultants have often been employed to study the organization. More often such "outside experts" would be employed to solve some problem in a narrower field. Recently, the writer has been admiring the use of a consulting organization for purposes of personnel evaluation and to give us

guidance in the effective use of the people who work for the doctors of Pennsylvania. It is clear from observation of the work and the results that this is another example of good, modern management.

It is difficult to write an appreciative review such as this without resorting to superlatives. But the writer considers Lester Perry's supreme accomplishment to be his ability to delegate work and authority. Management and long and short range planning belong in the executive director's own sphere. But, once a project or plan of action has been delimited, Mr. Perry is invariably able to make an assignment without subsequently interfering with the member of the staff to whom the duty was entrusted or without reserving any portion of the task to himself. Throughout his organization one always detects a very strong skeleton of system. Every member of the staff has a clear and well defined pattern of authority. There is a firm scheme of reporting to authority so that assigned duties are always followed up and reports are always made. The echelon of authority and the systematization of the work of the staff are notable features of the State Medical Society's headquarters office.

Should anyone not personally acquainted with Mr. Perry be reading this encomium he will probably envision him as a very vigorous and forceful person with an aura of command presence. He could be seen as having all the qualities of the extrovert. Nothing could be farther from the mark. In spite of the positive virtues I have described, Lester Perrry is the epitome of modesty and the "soft sell." He is reticent, subdued and unassuming. His quiet manners have never been seen to fail him and he is one of the persons whom I can prove to be always a gentleman.

We can expect a perfectly smooth transition as the "old order changeth."

And now, Mr. Perry is leaving us as our executive director. It might seem that the loss could be seen as a serious set-back to the Society, but this is far from the truth. Not only is Les a superlative manager but he is also a first rate planner. And he is a pedagogue at heart. His early training has borne fruit and he has built up an organization and a staff which has already begun to function in his stead. We can expect a perfectly smooth transition as "the old order changeth." There should not even be a slight jar as the new machine slips into gear and proceeds along the lines laid down by the old master. And there will be time for the new executive director to manage the society's affairs under advice, while he establishes himself in his new authority.

We Pennsylvania physicians should count ourselves fortunate in having had the long-term services of Mr. Lester H. Perry. And we expect to see him in his usual habitat from time to time, observing his organization continue to produce results for organized medicine and for Pennsylvania.

CBL

HOMAGE TO LESTER PERRY

Until every rock is precisely where he feels it belongs...

At a fraternity initiation, Les Perry was blindfolded, relieved of his pocket money, taken about twelve miles out of Pittsburgh at 2 a.m. one morning where he was given a fifty-pound rock that he was to have back at the frat house by daybreak.

That was about 1923. The thousands of persons who have come to know him even casually in the years since don't even have to ask whether or not Les met the test.

They know the outcome because they watched Mr. Lester H. Perry, the executive director of the Pennsylvania Medical Society, rolling far bigger and more unwieldy rocks than that—rolling them out of the way if they stood as barriers to a medical society goal or breaking them down into units from which he caused to be built a stairway to progress.

This month when the House adjourns its 1969 session and Les retires as executive director, a look at his thirty-five years of service to the State Society reveals many of the rocks and boulders shaped and standing as monuments to the meaningful developments in organized medicine in Pennsylvania and, in fact, in the nation.

Don't be misled by that description into envisioning a muscular giant. His tools are words that say precisely what he wants them to—words selected and put together with almost infinite care and thought, the degree of which is unknown to all but his closest associates. A physical giant? No—his height and build are average. A mental giant? Yes—his probing, analytical, perfectionistic approach to problems and possible solutions is almost always a bit awesome and sometimes even devastating. Les sometimes will take hours and hours to prepare remarks that are delivered in five minutes.

The unusual combination of genes and environment which shaped the man isn't apparent in the facts of his early curriculum vitae. His childhood and youth might be classed as average. He was born in Pittsburgh June 13, 1904. His father was a machinist for the Jones and Laughlin Steel Corporation and he was the eldest of three sons and two daughters, one of whom died in infancy. His mother died when he was fourteen and his father remarried about ten years later. His first serious career goal—while he was attending high school—was that of minister, probably influenced by a great-grandfather who was a locally ordained clergyman. That interest waned and his high school studies were commercial subjects—typing, shorthand, bookkeeping, etc.

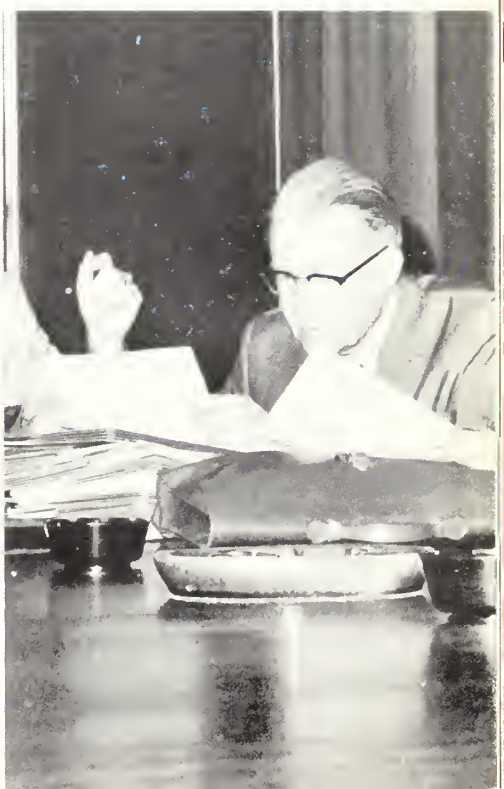
With the same high school background today, Les says he probably would not be accepted at any college but in 1921 he had no difficulty meeting the entrance requirements at Pitt where he started out in the college of liberal arts and transferred as a junior to the school of education. He was awarded his A.B. degree in 1925 at which time he would have liked to secure a graduate assistantship in English. Instead, after a summer fill-in job swinging a pick and shovel for a contractor, he went to McKees Rocks High School for two years as a teacher of English and "problems of democracy" and then returned to Pitt as assistant dean of men for four years.

His service to organized medicine started in 1931 when he resigned at Pitt to become the first executive secretary of the Allegheny County Medical Society. His work there won him three years later an opportunity to be managing editor of the Pennsylvania Medical Journal and convention manager of the Medical Society of the State of Pennsylvania, with offices in Harrisburg. This change to the State Society took place in 1934.

Very little in the work experience or education of the man seemed to be pointing Les toward a career in association management. As a boy, he was a newspaper carrier and later was promoted to collection agent. He worked on the nearby farms hoeing corn or doing a variety of other farm chores when the pay was a dollar a day. He worked for a man who had obtained a patent on a safety razor and who competed with the safety razor giants from a neighborhood shop where Les helped assemble the razors and filled orders. College was somewhat of a financial struggle for the family and he held a variety of part-time jobs with the Post Office Department, as an elevator dispatcher, as an usher or ticket salesman at football games, as a magazine salesman and once as a demonstrator-salesman of "waterless cookware."

About the time Les finished high school, he met Margaret Knowlson who was to become his wife a month after he was graduated from Pitt. Les and Peg have two children—Jane (Mrs. Alfred L.) LeVan, of Gettysbury, and John, at home.

Back to that fraternity initiation



for a moment: Les not only got that fifty-pound rock back to the dorm in time to avoid punishment; he participated in a Pitt track meet the same day despite the all-night struggle with the rock. The usual track events in which he competed were the 100 and 220 yard dashes.

When Les came to the state medical society in 1934 to edit the journal and manage the conventions, he was one of a staff of three persons. One of the first of the additional duties that rapidly came to him was promoting periodic health examinations, a project of the then Public Relations Committee of the State Society. The late Chauncey Palmer, M.D. started to work as the State Society's "legislative engineer" at about the same time and Les assisted him to a fluctuating degree in the years that followed.

"...an unseen force in all that has transpired..."

To recite the history of Les Perry in the years since 1934 would be to recite the history of the Pennsylvania Medical Society. Les was a part—sometimes a modest part, often a major one—of all that happened to organized medicine and the State Society in those years.

Asked to select one or two events of those thirty-five years that he considers to be most significant to organized medicine, he responded with one immediately and added a second one a bit later.

The first one he listed was the establishment of the Medical Service Association of Pennsylvania—Blue Shield—one of the first three such plans in the nation and today, in terms of the number of people served, the largest. Only those who lived through the trials and tribulations surrounding of formation of Blue Shield in the late 30's and early 40's could know how significant was the role that Les Perry played in the divisive, see-saw battles at which the birth, life and death of Blue Shield were determined. For seven years—from its inception until the Blue Shield Plan "got out of the red"—Les served as its unpaid executive director in addition to his duties with the State Society. He was one of the nine original incorporators of Blue Shield and was elected secretary of its corporation at its first meeting and has continued to serve in that capacity for the more than twenty-nine years since. He also has been a member of the Blue Shield Board of Directors for the same period except for a one-year interval.

Those involved in the stormy, shaky beginnings of Blue Shield credit a Les Perry report to the House of Delegates at the 1945 session as being a deciding factor in preventing the then imminent death of the plan. Les addressed the House at that session (the only time he has been asked to do so) and the subsequent discussion and actions by the House of Delegates and Board of Trustees ultimately resulted in the financial support needed to save Blue Shield.

Perhaps the second most significant event? Les thought for a while and then came up with: the establishment of the State Medical Society's first broad-based public relations program in 1947. In that year and the several that followed, there came into existence many of the solidly based public relations programs that exist today. These include such things as the Centenarian Award, designed by Les to commemorate the centennial of the State Society, and the Benjamin Rush Awards which established the State Society as the organization best qualified to judge contributions to the health and well-being of the public.

Les spoke to the 1947 Conference of Secretaries and Editors, the name of which was later changed to the Officers' Conference, and in one portion of his presentation said,

"Public relations is not a pitched battle of propaganda between two determined and unyielding forces. Its results are no longer measured by the number of column inches of publicity appearing in newspapers. On the contrary, some of the finest accomplishments in the field of public relations consist of new solutions to old problems developed and refined in the crucible of self-respecting compromise and cooperation between persons with divergent views. Such results are usually achieved without benefit of newspaper headlines or the blare of human trumpets. As a consequence, it often happens that only the most discerning recognize an outstanding job of public relations when they see one. . ."

To look through all of the thirty-five years that Les has served as the administrative head of the State Society is to find scores and scores of individual events in which he has participated. However, perhaps his greatest contribution transcends the specific activities of which he has been a part to become an unseen force in all that has transpired and will transpire for many years to come. This contribution is the development of the staff that assists him—a development that results in staff members as individuals

and as a team working at a level of accomplishment that could not be achieved with the average administrator. He has been a superb teacher although the lesson is sometimes taught in ways that leave the subordinate feeling like an elementary school pupil. Les gets out of others a level of performance that sometimes even surprises the performer.

If the rock-rolling made him sound like a physical giant, this portion may make him sound like a man without faults. Attempting to make a list of faults to season the virtues usually depends on the observer's viewpoint and some of the things that one would class as faults might be considered as virtues by another, and vice versa. For instance, Mr. Lester H. Perry is a maddeningly perfectionistic person about virtually everything with which he comes into contact. An uneven window blind, a picture slightly askew, a word improperly used, all have to be corrected immediately or Les will fidget and squirm until they are corrected. He has a prodigious memory and some of his subordinates would add, "especially for mistakes that we have made." In attempting to keep track of the time that he devotes to the medical society, it would be a fair assumption to assume that his family frequently feels neglected. Les is a stubborn man. To change his mind requires an overwhelming amount of facts. But who can class such things as super-perfectionism, extreme devotion to work or mental tenacity totally as faults or totally as virtues?

Les was asked if he had ever lost his temper publicly and there was a long pause while he analyzed the semantics involved and avoided a direct answer by saying that there had been several occasions when many persons felt that a display of anger on his part would have been justified. Then he paused again and added, "I suppose I've been angry several times."

One of his characteristics is the presentation of infinitely researched, superbly thought out ideas which he refuses to coat with salesmanship. When he finishes thinking out a problem and putting his conclusions down on paper, he feels that the facts as he has presented them should "sell" themselves without any buttonholing on his part. "If an idea is worthy of acceptance," Les Perry says, "it will never die—even if it is rejected several times."

Considering the clear precision with which he writes, it should be no surprise that he is the author of numerous published articles, many of which have been in various medical journals but two of which have been published in magazines of general circulation. He wrote "How to Harness Your Subconscious" for the magazine *Your Life* and "Death Has No Terror" for *Reader's Digest*.

In job-related activities, he served in 1956-57 as president of the Medical Society Executive Association—the national trade association for employees of medical societies; as a member of the governing board of the organization now known as the National Association of Blue Shield Plans; as a member of the Public Relations Advisory Committee of the American Medical Association and as chairman of that committee for one year. In 1951, the magazine *Medical Economics* selected him as one of eleven men to compose its "All-American team of state medical society executives."

With these and an almost endless number of job and job-related activities, it is difficult to see how he had time for community affairs but he did—again, to an amazing degree. He was a school director for almost a quarter of a century in the Harrisburg suburb where he lives—Lemoyne—and also served on two joint boards in the area. During those years he served at various times as president and vice-president of two of these boards and vice-president of the third. He was a member of the Board of Trinity Lutheran Church in Lemoyne and, later, of the Unitarian Church of Harrisburg which he also served as president and vice-president. He is a member of the Harrisburg Rotary Club and belongs to a variety of other local organizations.

Following his retirement as executive director of the Pennsylvania Medical Society this month, he will remain with the state society as a consultant on financial and special problems. He admits that it would be almost impossible to cope with the nostalgia should he drive by the Pennsylvania Medical Society headquarters building in Lemoyne with all ties severed.

Les, then, is stepping down from a particular position rather than stepping out of a life of organized medicine. The latter is something that he probably would be incapable of doing anyway. He's incapable of "retiring from" anything and the change marks a "retirement to."

The years have taken a minor toll

physically. In 1953 during a physical examination for life insurance, it was discovered that Les had diabetes but, except for a brief hospital stay when insulin was used, this has been controllable by diet and oral medication. About two years ago, cataracts were removed from both eyes and because of an incompatability with contact lenses, his glasses bear the thick lenses typical of the post-cataract patient.

Les Perry is a sports fan, especially baseball, and has a greater than average interest in psychology.

There is the feeling that the rocks in the field to which Les Perry is retiring won't present much more of an obstacle than did that fifty-pounder involved in his fraternity initiation. Somehow, all of the rocks in that consultant field that stand as barriers to what he wants to do will be moved out of the way or chiseled down into pieces from which something new will be erected. You can be sure that Les Perry will fidget and squirm until every rock is precisely where he feels it belongs. **DANE S. WERT**

The Other Side of Lester Perry

A man of the stature of Lester H. Perry usually is a man of many sides, and the executive director of the Pennsylvania Medical Society is no exception.

A gifted man—for any man who can take directives from an association of professionals, refine them, and direct a staff to bring them to fruition, is gifted—he is also a very human man.

Picture the grandfather, on a cold, damp, football-weather Sunday afternoon. He could be at home in the comfort of the gracious colonial home he and his wife, Peg, built in 1941 on a hillside in Lemoyne. He could be watching, on television, the Steelers, or the Colts or Eagles, play almost perfect football, for these are professional teams. But Lester Perry is standing in the drizzle in a New Cumberland park watching his twelve-year-old grandson play a typical, young-boy's football game. For Lester Perry, the sports fan, Lester Perry, the admirer of the right move at the right time, this is another side. This is the side which shows that such a man, despite almost twenty-four hour a day devotion to career and civic affairs, does make time for his family. His family will attest to this. They are: his wife, his daughter, who is married to Alfred L. LeVan of Gettysburg, the grandchildren, football player James and eight-year old John, and his son, John Lester.

Both Mr. Perry's son and daughter follow in his footsteps to the degree that they entered the teaching profession, but Jane has been busy with the career of wife and mother and has just decided to take a course at Shippensburg with the idea of returning to teaching as her children grow older.

John's creative talents display themselves in painting and photography while his father's are revealed in his writings. John is teaching art this year, as well as working to improve his talents whenever time permits. He lives in the family home in Lemoyne, a community where the Perrys have lived ever since 1934 when the Pennsylvania Medical Society first brought the family to the Harrisburg area.

Mrs. Perry—"Peg" explains that they were attracted to the West Shore because it reminded them of the hills of their native Pittsburgh. She says they used to drive through the farmland of the area, which is now a part of Harrisburg's suburbia, just to enjoy the view. "When we built our home, it was possible to look out and see for miles, with farms and hills as the picture in the window." Now the picture in this window includes a number of modern homes and office buildings, including the Pennsylvania Blue Shield building and PMS Headquarters, structures that certainly represent important factors in the lives of the members of this family.

Perhaps it is the wife of a man who has risen to the top of his chosen field,

and has received many honors along the way, who should be the star of the event of retirement. She is, in a sense, reclaiming her own. But there is unquestionably a sense of having shared the work and the accomplishments in this family—perhaps a living proof that "they also serve who only stand and wait."

Certainly Mrs. Perry has lived her husband's career with him, but she looks forward to having him at home more than he has been. She is quick to say, "I know he'll keep busy in the affairs which have been his life's work." One senses she is happy, though, that the pressures will be lessened and that his time will be his own more than ever before. She remembers details about the growth of the Pennsylvania Medical Society which have been forgotten by many who have been involved directly. She speaks with awe about the growth of Pennsylvania Blue Shield. "We never dreamed it could grow so rapidly in a few short years." And she remembers the human touches—annual picnics, and gatherings. Particularly she recalls the picnic on July 18, 1950, because it fell on the occasion of the Perrys' twenty-fifth wedding anniversary. "The society employees presented us with a gift of silver—and it meant a great deal to us."

Most of all one is impressed with the smile of Peg Perry when she speaks of her husband and his work. Surely she has served as first mate far beyond the call of duty.

So this family is an integral part of the man, Lester H. Perry, and as they have been lifted by his leadership as head of the house, so he has been lifted by their presence.

A man of many sides: one who believes in doing his share to conserve what is good for people, both in human and natural resources; a creator, whose every effort is bent toward making what he creates the best possible; and a husband, father, and grandfather who watches football games in the rain, who by attending to this and other family affairs, builds a wealth of understanding between generations.

Lester H. Perry, *above left, PMS executive director, receives a plaque in recognition of his outstanding service to the medical profession at a dinner in his honor given by the Dauphin County Medical Society. Looking on are, left to right, David A. Smith, M.D., president elect; R. Edward Steele, M.D., DCMS president, who made the presentation; and Alfred J. Sherman, M.D., first vice-president.*

The Perennial Challenges of Medicine

A thought provoking address to

The Dauphin County Medical Society

By Lester H. Perry

delivered at a reception and dinner held May 6, 1969

My reaction as I accept this plaque is a blend of humility and gratitude. People often ask me if I am a doctor. When I tell them no, they sometimes ask if I wanted to be a doctor. My answer to that question is also in the negative and for a very simple reason. I do not have the mental and emotional equipment to be a good physician. Consequently, when I am the recipient of an accolade such as this from the members of a great profession whose qualifications I am unable to meet, I feel very humble.

I am also deeply grateful. I appreciate your thoughtfulness in having me as your guest this evening and in giving me this plaque, which I assure you will take its rightful place among my most cherished possessions. But I am also grateful for your kindness and consideration to me throughout the years. Thank you very much.

When I first heard of your plans for this evening, I was particularly touched by your generosity in arranging for this most pleasant occasion because I didn't think that I had done any more for the Dauphin County Medical Society than I had for any other component society. Upon reflection, however, I changed my mind because I did play a decisive role in the original selection of your capable and dedicated executive secretary for his first assignment in the vineyard of organized medicine, and I also like to take at least a little credit for Bill Harlan's early training in the work which he now does so very well. I have concluded, therefore, that I have made a greater contribution to this progressive society than to most of the others even though I have done so vicariously through the talents of Bill Harlan.

In January, when I received your invitation, I addressed a memorandum to nine of my colleagues on the State Society staff which read in part as follows:

> "I have been invited to address the Dauphin County Medical Society on any subject which is important and timely for physicians. Will each of you please give me the benefit of your advice regarding subjects you would recommend for this presentation, including a summary of what you think should be said about such subjects"

The responses to that memorandum totalled seventy pages and contained thirty-six suggested topics for my discussion. In order to indicate their diversity, let me mention just a few: Comprehensive Health Planning—Malpractice Insurance—Periodic Relicensure of Physicians— Lay Domination of the Medical Profession.

After careful study of all the responses from my colleagues and with a sense of guilt at the prospect of not utilizing the fruits of their labor, I rejected all their suggestions primarily because I was overwhelmed and could not decide which of the thirty-six was the most appropriate subject to discuss with you tonight. In addition, however, since concrete problems are by their very nature transistory, I wondered if my thirty-five years of service with the Pennsylvania Medical Society would enable me to make some observations about the perennial challenges which face the medical profession in the solution of any of its problems regardless of their character or the time of their appearance. If I am able to do this successfully, my comments should have constructive application not only to the problems of today but to the problems of tomorrow as well.

More than two thousand years ago Heraclitus concluded that nothing was constant except the phenomenon of change. "Nothing is permanent," he said. "Though things may appear to remain stable, they are really in a perpetual state of flux. You could not step twice into the same rivers, for other and yet other waters are ever flowing on."

The fundamental truth of Heraclitus' observation applies as certainly to the practice of medicine today as it did to the rivers of ancient Greece employed by the old philosopher to illustrate his teachings. The life of the world is constantly being altered by the achievements of modern medi-

cine; and the activities of physicians are constantly being modified by the economic, social, and political developments of the world in which they live.

The problems you face are different from those of your predecessors. Their elements include not only germs and pain and medication and surgery but also social philosophy and economics and legislation and public relations.

The medical profession today is involved in an ever-increasing number of health programs financed by the Federal Government, and their concern about these programs is neither appreciated nor fully understood. The real issue, it seems to me, is frequently obscured in a tangle of detail; nevertheless, it lurks at the center—stark and sobering in its reality. Can democracy, as we know it, continue to exist if the central government grows increasingly paternalistic and totalitarian by taking over more and more of the responsibilities which were once accepted by the people themselves, their families and friends, the church, voluntary health and social agencies, the fifty states, and local units of government?

Last week I showed the first draft of these remarks to an intelligent and liberal-minded young friend of mine who has a Ph.D. in political science. I asked him to criticize what I had written with unrestrained candor.

When he came to the rhetorical question I just read to you, asking whether or not our democracy could survive, he told me that this comment was typical of the doctrinaire and misleading criticism being made today by unrealistic conservatives who still live in the political atmosphere of the nineteenth century and delude themselves with their own sophistry.

I had asked for candor, and he socked it to me. However, since I consider my own political philosophy to be a reasonable although somewhat dichotomous blend of conservatism and liberalism, I questioned the validity of his rebuke and sought both refuge and perspective in some re-reading of history.

In the limited time available, this is what I found. So far as ancient history is concerned, democracy reached its zenith in the city-state of Athens during the "Golden Age of Pericles" in the fifth century before the birth of Christ. The history of Athens sparkled with brilliance for about a hundred years and then, in the words of Dr. William F. McDonald, professor of ancient history at Ohio State University, "the history of Athens was not at all important."

Professor Alexander Tyler, a noted authority on the history of democracy who lived during the eighteenth century and wrote extensively about the decline and fall of the Athenian Republic, came to this conclusion:

> "A democracy cannot exist as a permanent form of government. It can exist only until the voters discover they can vote themselves largess out of the public treasury. From that moment on the majority always votes for the candidate promising the most benefits with the result that democracy always collapses over a loose fiscal policy, always to be followed by a dictatorship."

The erosion of democratic principles is often so gradual as to be also imperceptible and, consequently, is usually either ignored or minimized by most of the people. Nevertheless, this disintegration of the body politic continues to spread like a cancer—quietly, slowly, relentlessly—until finally, when the malignant results become apparent to the casual observer, it is too late. The very imperceptibility of this process intensifies a hundredfold the problem of stopping it.

The first challenge, therefore, is the challenge of vigilance. By this I do not mean blind opposition. What I do mean is that each new health proposal should be judged in the crucible of critical and objective analysis. Its good points should be acknowledged and its faults exposed. This challenge applies not only to governmental programs but to the proposals of hospitals, labor, management, or any other segment of society. If the program is a good one, it should be supported; if it is basically sound but contains certain weaknesses, it should be strengthened; if it is fundamentally bad, it should be opposed.

With such a maelstrom of contending social forces as exist today, we must remember above all else that—regardless of whether their decision is right or wrong—in a democracy the voice of the people ultimately prevails. Consequently, in matters of health it behooves organized medicine to guide the public to a sane conclusion. As the initial step in this direction, public confidence must be secured.

The medical profession, however, cannot hope to get very close to the soul of the heterogeneous American public by national or state activities alone. Together, these form an excellent foundation; but the superstructure must be built to fit into the local landscape.

In Dauphin County you have a progressive medical society with a capable executive secretary and a forward-looking program which was outlined in concise and lucid language by Dr. R. Edward Steele as he delivered his inaugural address when he was installed as your current president. Let me quote the final sentence of that address:

> "I am quite sure that—if your officers, council and committee chairmen have your active participation, your continued interest, and your enthusiastic support—we will make 1969 a most fruitful year."

In that incisive sentence Dr. Steele has focused the spotlight on the second perennial challenge of medicine—the challenge of involvement—for in this arena you cannot afford to sit on the fifty-yard line and cheer. Responsibility for medical leadership rests squarely upon the individual physician and upon that most strategic unit in the structure of organized medicine—the county medical society. Participation by physicians as individuals in the direction of health activities is a source of genuine influence, and galvanizing the latent power of that influence into action is one of the county society's most important problems.

Among your officers, the members of your Board of Governors, and your council and committee personnel you have a remarkable pooling of the best medical talent available. Through their expert services, generously contributed, effective solutions to important health problems can be achieved which would be impossible for employees or individual members working alone. Every member of the Dauphin County Medical Society owes a debt of gratitude to the busy practitioners who bring to such endeavors a quality of service which could not be purchased at any price, and the best way they can pay that debt is to become involved in the activities of the Society.

Even the most casual reader of medical history must be impressed by the glorious achievements of the profession in its conquest of baffling scientific problems. He must be particularly thrilled when he discovers, upon looking more closely, that the brilliance which shines through almost every page of the history of medicine is but the reflection of an unparalleled devotion to the duties of humanitarian ser-

vice on the part of countless thousands of individual physicians. Without a repetition of that traditional devotion to duty which characterized the attack upon the scientific front, worthwhile progress in this new constellation of problems can never be accomplished.

In recent years great stress has been placed upon public relations in the solution of the problems of the medical profession, and the importance of effective public relations cannot be denied. However, it seems to me that we have a tendency to talk and do a great deal about public relations without first defining our terms. What is public relations? Let me give you my definition as it applies to medicine:

> "Medical public relations is a continuous process by which the medical profession endeavors to obtain the confidence and goodwill of the public—inwardly by self-analysis and correction to the end that the best interests of the people will be served, outwardly by all means of expression so that the people will understand and appreciate that their welfare is the profession's guiding principle."

If this definition is accepted, it follows that the enlightened conduct of individual physicians and the worthwhile activities of medical societies are the only raw materials out of which a successful public relations program can be built. There must be sincerity of purpose and a determined effort to do what's right by the people. There must be willingness to accept public opinion as a reality whether it is right or wrong and to submit to the microscope of truth even though it reveals pathologic conditions in the practice of medicine. This approach does not mean that we must be tepid in our convictions; it means only that we must be open-minded.

The third challenge, therefore, is the challenge of integrity because the confidence and good will of the people can be secured only by policies and accomplishments that are authentic and genuine without a trace of either hypocrisy or pretense. Public relations is neither a cover for shortcomings nor a substitute for good works. It cannot exist in a vacuum, it cannot be created by the alchemy of some magic formula, it cannot succeed as a half-hearted experiment, and it cannot be wrapped up in a package and delivered.

The logical approach to the problem of medical public relations begins with an effort to make our policies unassailable, our programs so important to the people themselves that they cannot be ignored, and our accomplishments so concrete and so clear-cut that they cannot be distorted even by the mental and emotional astigmatism of prejudicial detractors. In order to reach this goal, however, it is essential that a spirit of integrity permeate every aspect of medical practice and every program of medical societies. There is no substitute for integrity.

When I first began an intensive study of public relations more than twenty years ago, I was impressed by two factors: first, the broad scope of public relations; and second, its religious quality. As I contemplated this religious aspect of public relations, I began to wonder if I were not being hypnotized by the beautiful idealism of that concept until one day I came upon a quotation from the writings of Rex F. Harlow, who was then associate professor of public relations at Stanford University and president of the American Council on Public Relations. This is what Mr. Harlow wrote:

> "The Golden Rule is the key to all deep understanding of human reaction. It is, therefore, the foundation of all good public relations. Whether fully recognized or not, it is the basis of all successful efforts to improve the public relations of any business, any educational institution, department of government, or economic or social organization."

James E. Bryan, a friend of mine who has spent a lifetime of service to medical societies and related organizations, makes the same point a little differently. He is the author of a book entitled *Public Relations in Medical Practice,* in which he draws this conclusion:

> "Happy and wholesome public relations for the medical man is first and foremost a matter of attitude . . . Nowhere else in the entire spectrum of human endeavor is attitude more central to one's ultimate success or more crucial to one's public esteem.
>
> "Perhaps the synoptic word is charity. For, as St. Paul wrote to the Corinthians long ago: 'Though I have the gift of prophecy and understand all mysteries and all knowledge, and though I have all faith so that I could remove mountains, if I have not charity, I am nothing.' "

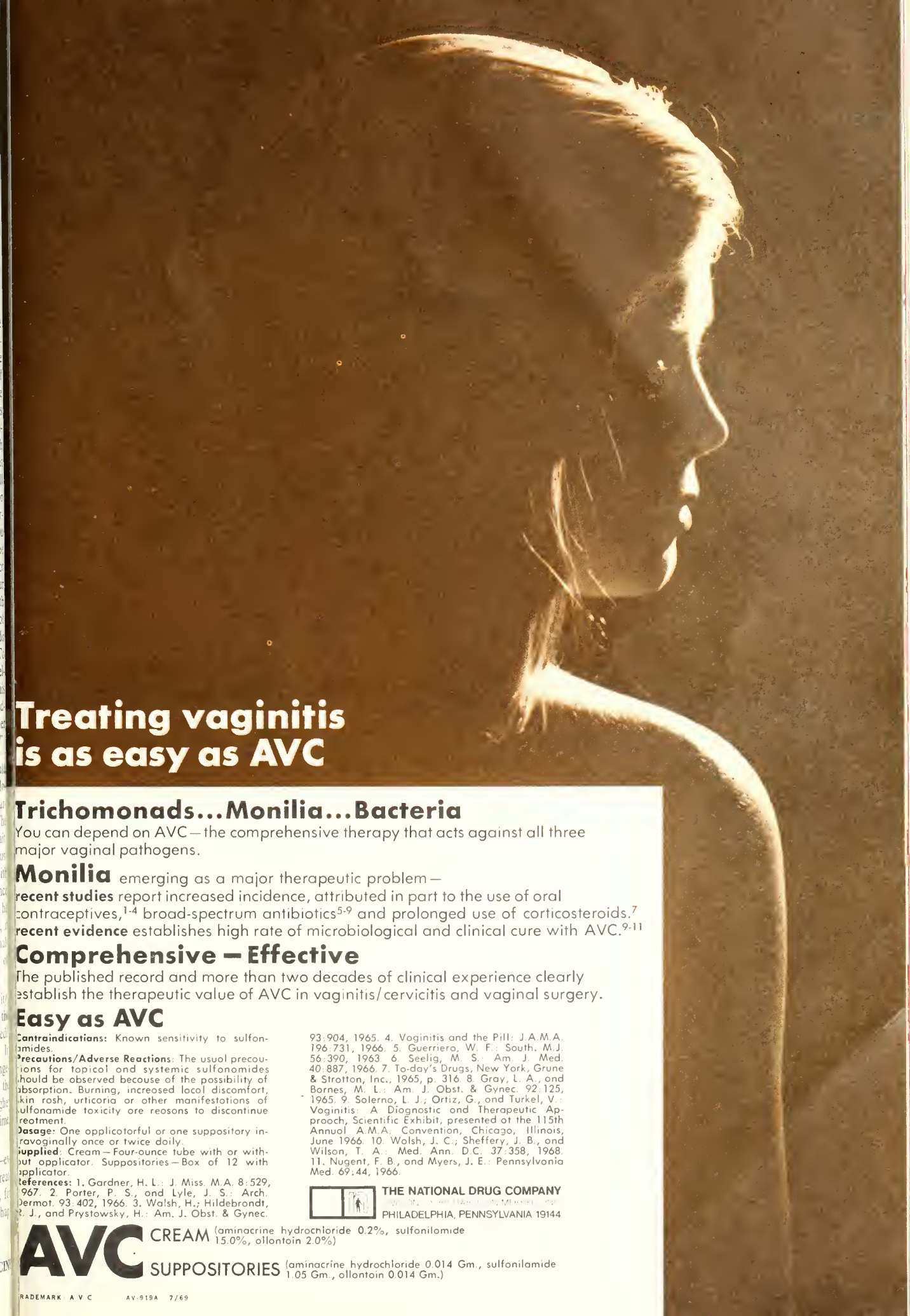
And now one final quotation—this time from the pen of a great physician who lived before there were any books written, any courses taught, or any societies organized in the field of public relations. On October 1, 1903, while addressing a group of medical students in Toronto, Sir William Osler emphasized the religious overtones of medical practice in these words:

> "More than any other person, the practitioner of medicine may illustrate the great lesson that we are here not to get all we can out of life for ourselves but to try to make the lives of others happier. This is the essence of the oft-repeated admonition of Christ: 'He that findeth his life shall lose it, and he that loseth his life for my sake shall find it' . . . It is not possible for anyone else to have better opportunities to live this lesson than you will enjoy. The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head. Often the best part of your work will have nothing to do with potions and powders . . . To you as the trusted family counsellor the father will come with his anxieties, the mother with her hidden griefs, the daughter with her trials, and the son with his follies."

There are several words which could be used to identify the quality so eloquently portrayed by Professor Harlow, Mr. Bryan, and Dr. Osler. The real essence of this humanitarian trait, however, is the sympathetic consciousness of another's distress blended with a sincere desire to alleviate it. Since no one can be a good physician if he lacks this inherent personal quality, it constitutes the fourth perennial challenge of medicine—the challenge of compassion.

Vigilance, involvement, integrity, and compassion—these are four of the most important challenges of medicine. But there are many more. In no other vocation are the challenges greater, and the demands upon the character of the physician are higher even than the demands upon his time, his energy, and his talents.

We the people—your patients—expect from you nothing less than greatness. And that is as it should be, for medicine is a noble calling—perhaps the noblest of them all.



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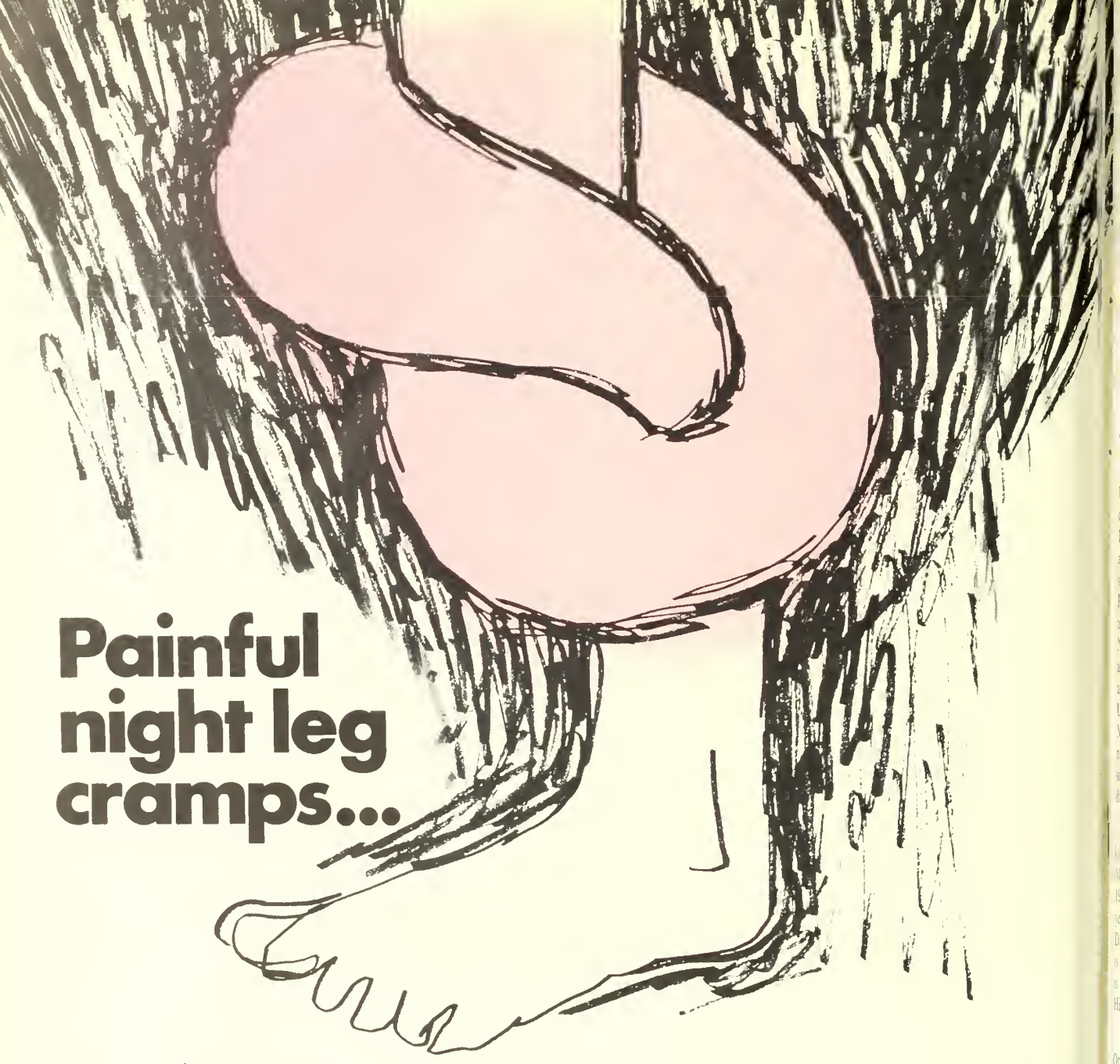

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○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Milo W. Cox,** Kane; University of Pennsylvania School of Medicine; age 84; died June 25, 1969. He had been honored for fifty years of service to the medical profession by the Pennsylvania Medical Society. He was a past president of the McKean County Medical Society. He is survived by his wife, a daughter and a brother.

○ **LeRoy W. Earley,** Pittsburgh; University of Chicago School of Medicine, 1942; age 52; died July 14, 1969. He was a Rhodes Scholar and studied at Oxford prior to entering medical school, and was a member of the Pittsburgh and Philadelphia Psychoanalytic Societies and the Pittsburgh Neuropsychiatric Society. He had held a number of teaching appointments, and was professor of psychiatry at the University of Pittsburgh School of Medicine. He held memberships in numerous professional societies. He is survived by his wife, two sons and a daughter.

○ **Edgar S. Everhart,** Camp Hill; University of Pennsylvania School of Medicine, 1907; age 89; died July 7, 1969. He practiced medicine for forty years, and served as president of the Dauphin County Medical Society. He is survived by two sons, one of whom is Wilson G. Everhart, M.D., Camp Hill.

○ **Benjamin F. Griffith,** East Orange, N. J.; Hahnemann Medical College, 1924; age 75; died June 28, 1969. He served in both World War I and World War II, and was active in Retreads, an organization of veterans of both wars. Surviving are several nieces.

○ **Austin Lamont,** Philadelphia; Johns Hopkins University School of Medicine, 1934; age 64; died June 21, 1969. He was one of the founders of the Association of University Anesthetists, and was a diplomate of the American Board of Anesthesiology. He was a sponsor of the Scholarship Fund for Negro Students at Johns Hopkins School of Medicine. Surviving are his wife, two sons and two daughters.

○ **Maurice M. Marmelstein,** Carbondale; University of Dublin, Ireland, 1935. He was a member of a number of professional associations, including the American Association of Ophthalmology and the Royal College of Surgeons, Great Britain. Surviving are his wife, three brothers and two sisters.

○ **Thomas G. McClellan,** Connellsville; University of Toronto Faculty of Medicine, 1924; age 70; died July 2, 1969. He was a diplomate of the American Board of Ophthalmology and served in Europe with the Canadian Tank Battalion in World War I. Survivors include his wife, a son, Thomas G. McClellan, Jr., M.D., and two sisters.

○ **Julius I. Newmark,** New Castle; Georgetown University School of Medicine, 1934; age 61; died June 30, 1969. He was former chief of staff of St. Francis Hospital, New Castle. Surviving are his wife, a son, a daughter, his father, a sister, and a brother, A. A. Newmark, M.D., of New Castle.

○ **Gerald H. J. Pearson,** Philadelphia; University of Western Ontario Medical School, Canada; age 75; died July 2, 1969. He was internationally known as a psychiatrist and psychoanalyst, and was professor emeritus of psychiatry at Hahnemann Medical College. He also taught at Jefferson Medical College and the University of Pennsylvania School of Medicine. He authored several books on Child Psychiatry and had membership in a number of psychiatric and psychoanalytic societies. Surviving are his wife, two daughters and a son.

○ **Harry O. Pollock,** Turtle Creek; University of Pittsburgh School of Medicine, 1916; age 76; died June 25, 1969. He had practiced medicine in the Turtle Creek Valley for the past fifty-three years, and had served at a base hospital in France during World War I. Surviving are a son and a sister.

○ **Joseph W. Post,** Wyncote; Hahnemann Medical College, 1909; age 82; died June 26, 1969. He was a radiologist, and in 1959 received the national physician of the year award. During World War I, he served in the Army Medical Corps in France. Survivors include his wife and a sister.

○ **Anthony Sindoni, Jr.,** Philadelphia; Georgetown University School of Medicine, 1927; age 69; died July 16, 1969. He was a specialist in diabetes and was author of thirty-one articles and books, including "The Diabetes Handbook." He is survived by two sisters and two brothers.

○ **Samuel M. Davenport,** Kingston; University of Virginia School of Medicine, 1927; age 77; died July 15, 1969. He was a fellow in the Industrial Medical Association and served as company surgeon for many years for the Erie-Lackawanna Railroad. Surviving are two sons, a daughter and three brothers.

○ **Robert W. Dunlap,** Rochester, Minn.; Johns Hopkins University Medical School; age 87; died July 23, 1969. He had served as a medical missionary in China for eighteen years and practiced medicine in Washington, Pa. from 1927 to 1959. He is survived by two daughters and three sons.

○ **Frederick H. Ehmann,** Philadelphia; University of Pennsylvania School of Medicine, 1921; age 73; died August 3, 1969. He served on the faculty of the University of Pennsylvania School of Medicine for twenty-five years, and served as medical officer for the Pennsylvania Reading Seashore Railroad Lines, besides maintaining a general practice. He is survived by his wife, two sons, a daughter and a sister.

○ **Cortland W. Elkin,** Pittsburgh; Johns Hopkins University School of Medicine, 1913; age 84; died August 12, 1969. He had served as chief of staff of Allegheny General Hospital and had practiced medicine for more than fifty years before retiring in 1962. He is survived by his wife and two brothers.

○ **Eugene H. Mohr, Jr.,** Alburtis; Temple University Medical School, 1927; age 69; died July 21, 1969. He had served the community as its only doctor for more than forty years. He is survived by his wife, a son and a daughter.

A list of educational opportunities offered to physicians in the interest of maintaining their competence and skill. Unless otherwise indicated, all courses are designed for physicians engaged in primary patient care.

ARTHRITIS AND RHEUMATISM

October 14, 1969; Chester

I/AMA—**Clinical Evaluation of the Inflamed Joint Including Synovial Analysis** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

CARDIOVASCULAR DISEASE

October 15, 1969; Pittsburgh

C—**Diet in Cardiovascular Disease—Current Research and Practical Applications;** by Pa. Heart Assoc., Pa. Dietetic Assoc., Pa. Dept. of Health and Western Pa. Heart Assoc.; at Holiday House, Monroeville. $7 fee (includes lunch). Contact Western Pa. Heart Assoc., 709 House Bldg., 4 Smithfield St., Pittsburgh 15222.

October 16, 1969; Erie

C—**Diet in Cardiovascular Disease—Current Research and Practical Applications;** by Pa. Heart Assoc., Pa. Dietetic Assoc., Pa. Dept. of Health and Northwestern Pa. Heart Assoc.; at Shrine Club. $7 fee (includes lunch). Contact Northwestern Pa. Heart Assoc., 902 Diamond Park, Meadville 16335.

October 16-17, 1969; Erie

I/AMA—**Arterial and Venous Diseases of Extremities** (Program of Continuing Medical Education—twice a month, Sept.-Dec.); by Jefferson and Penn State; at St. Vincent Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

October 22, 1969; Harrisburg Hospital

C—**Cardiopulmonary Resuscitation Instructors' Training Course;** by Pa. Heart Assoc., Harrisburg Hosp. and South Central Pa. Heart Assoc. $15 fee. Contact Pa. Heart Assoc., Box 2435, Harrisburg 17105.

October 28, 1969; Chester

I/AMA—**Pulmonary Heart Disease** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 28, 1969; Johnstown

I/AMA—**The Coronary Care Unit** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

"CODE KEY"

C—Consecutive days
I—Intermittent
O—Circuit
PG—Postgraduate Traineeship
R—Radio
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AMA—AMA Accredited Institution
C E S—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Penn-Grad—University of Pennsylvania, Division of Graduate Medicine
Pitt—University of Pittsburgh School of Medicine
Pitt P.H.—University of Pittsburgh Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania School of Medicine
Woman's—Woman's Medical College of Pennsylvania

October 29, 1969; Wilkes-Barre

I/AMA—**Bedside Cardiology** (Program of Continuing Medical Education—6 Wednesdays in September and October); by Hahnemann; at Wyoming Valley Hospital, 5 hrs. Contact David W. Kistler, M.D., Director, Wyoming Valley Hospital, 149 Dana St., Wilkes-Barre 18702.

CHEST DISEASES

October 16, 1969; Williamsport Hospital

I/AMA—**Clinical Pulmonary Physiology and Its Relation to Treatment** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 23, 1969; York Hospital

I/AMA—**New Theory and Approaches to Bronchial Asthma** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

GASTROENTEROLOGY

October 19, 1969; Latrobe Hospital

C—**Newer Concepts in Gastrointestinal Disease;** by Pitt and West Penn and Shadyside Hosps.; 5 hrs. AAGP credit, $15 fee. Contact John B. Hill, M.D., West Penn Hosp., 4800 Friendship Ave., Pittsburgh 15224.

October 30-31, 1969; Erie

I/AMA—**Ulcerative Colitis** (Program of Continuing Medical Education—twice a month, Sept.-Dec.); by Jefferson and Penn State; at St. Vincent Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

GENERAL MEDICINE

Every Thursday; Hazleton State General Hospital

I—**Program of Continuing Medical Education by Hazleton Branch, Luzerne County Medical Society.** Contact Robert Gunderson, M.D., Suite 412 Northeastern Building, Hazleton, Pa. 18201.

October 7, 1969—March 3, 1970; East Stroudsburg

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—First Tuesday each month, 6 sessions); by C E S; at Monroe County General Hospital; 18 hrs. AAGP credit applied for; $25 fee ($8 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 8, 1969—May 13, 1970; Somerset Community Hospital

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Second Wednesday each month, 6 sessions); by C E S; 18 hrs. AAGP credit applied for; $25 fee ($8 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 15, 1969-December 3, 1969 (Wednesdays); Philadelphia

I/AMA—**Recent Advances in Medicine;** at Temple; 32 hrs. AAGP Credit; $50 fee. Contact Albert J. Finestone, M.D., Dept. of Med., Temple, Broad & Tioga Sts., Phila. 19140.

October 15, 1969-April 8, 1970; Meadville

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Alternate Wednesdays, 11 sessions); by C E S; at Spencer Hosp.; 33 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvana Medical Society, Taylor Bypass & Erford Road, Lemoyne, Pa. 17043.

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continuing education

October 16, 1969; Altoona Hospital

I/AMA—**Hepatitis, Consecutive Case Conference** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

October 16, 1969; Wilkes-Barre General Hospital

I/AMA—**Disease of Laboratory Origin** (Program of Continuing Medical Education—One Thursday each month); by Jefferson & Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

October 16, 1969; York Hospital

I/AMA—**The Pathogenesis of Organic Disease in the Alcoholic** (Program of Continuing Medical Educaiton—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

October 21, 1969—May 19, 1970; Bradford and Kane

1—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Third Tuesday each month, 6 sessions); by C E S; alternately at Bradford's Penn Hills Club and Kane Manor; 18 hrs. AAGP credit applied for; $25 fee ($8 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 22, 1969—April 1, 1970; Sharon General Hospital

1—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Alternate Wednesdays, 10 sessions); by C E S; 30 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 22, 1969—April 1, 1970; Uniontown Hospital

1—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Alternate Wednesdays, 10 sessions); by C E S; 30 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

October 23, 1969; Bethlehem

I/AMA—**Vascular Response to Altered Immunity** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

GENERAL

October 30-31, 1969; Philadelphia

C—**Blood Cells as a Tissue** (Sixth International Tissue Research Conference); at Lankenau Hosp. Contact William L. Holmes, Ph.D., Div. of Research, Lankenau, Lancaster & City Line Aves., Philadelphia 19151.

INTERNAL MEDICINE

October 15, 1969; Wilkes-Barre

I/AMA—**Recent Advances in the Laboratory** (Program of Continuing Medical Education—6 Wednesdays in September and October); by Hahnemann; at Wyoming Valley Hospital; 2 hrs. Contact David W. Kistler, M.D., Director, Wyoming Valley Hospital, 149 Dana St., Wilkes-Barre 18702.

October 21, 1969; Chester

I/AMA—**Cyclic Edema** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

MALIGNANT DISEASE

October 22, 1969; Hotel Bethlehem

C—**Scientific Symposium on Cancer of the Head and Neck;** by American Cancer Society, Northampton County Unit; 7 hrs. AAGP credit applied for; $6 fee. Contact C. F. Snyder, M.D., President, Northampton County Unit, ACS, 802 High St., Bethlehem 18018.

MICROBIOLOGY & IMMUNOLOGY

September-December, 1969, (3rd Thurs. ea. mo.); Bethlehem

1—**Immunology;** at St. Luke's Hosp.; by Jefferson; 20 hrs. AAGP credit; $20 fee (5 seminars), $7 each. Contact Michael L. Sheppeck, M.D., Med. Dir., St. Luke's Hosp., Bethlehem 18015.

METABOLISM

October 30, 1969; York Hospital

I/AMA—**Metabolic Aspects of Weight Reduction** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PEDIATRICS

October 22-December 10, 1969; Philadelphia

I/AMA—**Recent Advances in Pediatrics;** at Jefferson; 8 Wednesdays; 16 hrs. AAGP credit applied for; $50 fee. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia, 19107.

PSYCHIATRY

Fourth Friday each month, September, 1969—June, 1970; Butler

1—**Physician-Community Psychiatrist Seminar;** by Mental Health Guidance Clinic of Butler Co.; at YWCA; Hour for hour AAGP credit. Contact Robert L. Eisler, M.D., Mental Health Guidance Clinic, 128 S. Main St., Butler 16001.

October 15, 1969—March 4, 1970; Philadelphia

I/AMA—**Psychiatric Problems of Children (Basic);** at Hahnemann—Each Wednesday, 18 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 22, 1969—March 18, 1970; Philadelphia

1—**Basic Office Psychiatry and Psychosomatic Medicine;** at Temple—Each Wednesday, 20 weeks; 80 hrs. AAGP credit; $50 fee. Contact Barney M. Dlin, M.D., Director, Department of Psychiatry, Temple, Broad and Ontario Sts., Philadelphia 19140.

October 22, 1969—January 7, 1970; Philadelphia

I/AMA—**Clinical Seminars in Medical Psychiatry (Advanced);** at Hahnemann—Each Wednesday, 10 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

October 22, 1969—June 3, 1970; Philadelphia

I/AMA—**Psychology of Medical Practice: Seminars in Psychotherapy;** at Hahnemann—Each Wednesday, 30 weeks; AAGP credit applied for $50 fee. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

SURGERY

October 15, 1969; Scranton

I/AMA—**Evaluation and Preparation of the Patient for Surgery** (Program of Continuing Medical Education—3rd Wednesday each month, 8 months); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

meetings

OCTOBER

Annual Otolaryngologic Assembly of the University of Illinois College of Medicine, October 4-10, 1969, at the Illinois Eye and Ear Infirmary, Chicago, Ill. Contact Otolaryngology, P. O. Box 6998, Chicago, Ill. 60680.

American College of Surgeons Clinical Conference, October 6-10, 1969, San Francisco, Calif.

PMS Annual Business Session, October 8-12, 1969, Marriott Motor Hotel, Philadelphia, Pa.

PMS Woman's Auxiliary, October 8-12, 1969, Marriott Motor Hotel, Philadelphia, Pa.

American Academy of Ophthalmology and Otolaryngology, October 12-17, 1969, Chicago, Ill.

Conference on Old Age, Philadelphia Geriatric Center and Stephan Smith Home for the Aged, Monday, October 13, 1969, York House South, 5325 Old York Rd., Philadelphia.

Industrial Hygiene Foundation Annual Meeting, October 14-15, 1969, Chatham Center, Pittsburgh, Pa. Contact Robert T. deTreville, M.D., President, Industrial Hygiene Foundation, 5231 Centre Ave., Pittsburgh, Pa. 15232.

American College of Obstetricians and Gynecologists District Three Meeting, October 16-18, 1969, Pittsburgh Hilton Hotel, Pittsburgh, Pa.

Fourteenth Annual Conference of the Committee on Nutrition and Metabolism of the Philadelphia County Medical Society, October 22, 1969, Auditorium, Temple University Medical Center.

American Society of Anesthesiologists Annual Meeting, October 25-29, 1969, Hilton Hotel, San Francisco, Calif.

PMS Socio-Economic Seminar, 2 p.m., Friday, October 10, Delaware Ballroom, Marriott Motor Hotel, Philadelphia.

Pennsylvania Homeopathic Medical Society Convention, October 7-9, 1969, Hotel Hershey, Hershey, Pa.

American Academy of Pediatrics Thirty-eighth Annual Meeting, October 18-23, 1969, Palmer House, Chicago, Ill.

Northeastern Proctologic Conference Annual Meeting, October 30-November 2, 1969, Holiday Inn, Atlantic City, N. J.

NOVEMBER

American Society of Cytology Seventeenth Annual Scientific Meeting, November 6-8, 1969, Palmer House, Chicago, Ill.

American Public Health Association Annual Meeting, November 10-14, 1969, Civic Center, Philadelphia.

American Heart Association Annual Scientific Sessions and Assembly, November 13-18, 1969, Fairmont Hotel, Dallas, Texas.

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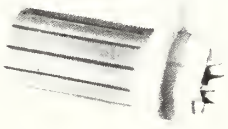

TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

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in my opinion

Shall PaMPAC Continue?

Perhaps it is because some of us who are so intimately involved and feel so keenly the need for this organization and its work that we ask ourselves this question in moments of despair and disillusionment. Many of us feel that less than half of the membership of PMS is a poor representation and surely not a mandate for positive action—this particularly when our profession is being battered from all sides by socialists, labor leaders and just plain demagogues, all with the same idea in mind—complete socialization of American Medicine.

Justice Holmes once said, "Behind every scheme to make the world over lies the question, 'What kind of world do you want?' " The members of our profession need not ask this question. We have been adequately advised by the Reuthers, by the Cohens and many others that satisfaction will never be appeased with less than complete socialism in medicine.

The handling of the "Knowles affair" by the Secretary of HEW indicates that half-truths, untruths and any other manner of handling—or mishandling—of departmental functions is acceptable so long as a "whipping boy" is at hand to absorb the punishment for the consequences resulting from mismanagement. When this is true of one of the largest departments in Washington, what may we look for in the future?

Then, again, consider the appointee designated by Secretary Finch to head the task force to review fees paid under Medicaid, one James G. Haughton, M.D. He is quoted in Medical World News as saying he stopped being a member "when the AMA assessed its membership to fight Medicare". Upon investigation, it was determined that Dr. Haughton had never belonged to the AMA.

When the truth is so difficult to come by in government, what can a single voice crying in the wilderness accomplish? The answer is "nothing." More than ever, it is necessary to have a strong, active organization to speak with some authority when elections roll around if anything worthwhile is to be gained in our appeals and requests.

One of our more conservative congressmen stated a short time ago that never in all his years has he encountered so many demagogues under one roof as he has seen in Congress at the present time. With the present Administration fighting inflation, we have too many congressmen who fail to vote their consciences. They now vote to increase spending by millions of dollars over and above that called for in the budget, thereby feeding the fires of inflation, solely to guarantee their vote-getting powers. We must have more elected officers who vote their better judgment rather than vote political expediencies. Who is in a better position to try and accomplish this than your political action committee.

Vice President Spiro Agnew in speaking before the AMA House of Delegates in New York said, "Not many physicians take an active part in politics". How true—and how sad. It would appear that in spite of admonishments from many in high places in the Federal and State Governments suggesting that all men of medicine should become very active in politics, a large number of our profession will not even join an organization willing to work for their interests. Too many are willing to live day-by-day and let the future bring what it may. What it brings may not be good, however.

To those who are not members of PaMPAC, I would suggest that we still need your help and, in so doing, you might help yourselves immeasurably in the near future.

WILLIAM B. WEST, M.D.
Chairman, PaMPAC

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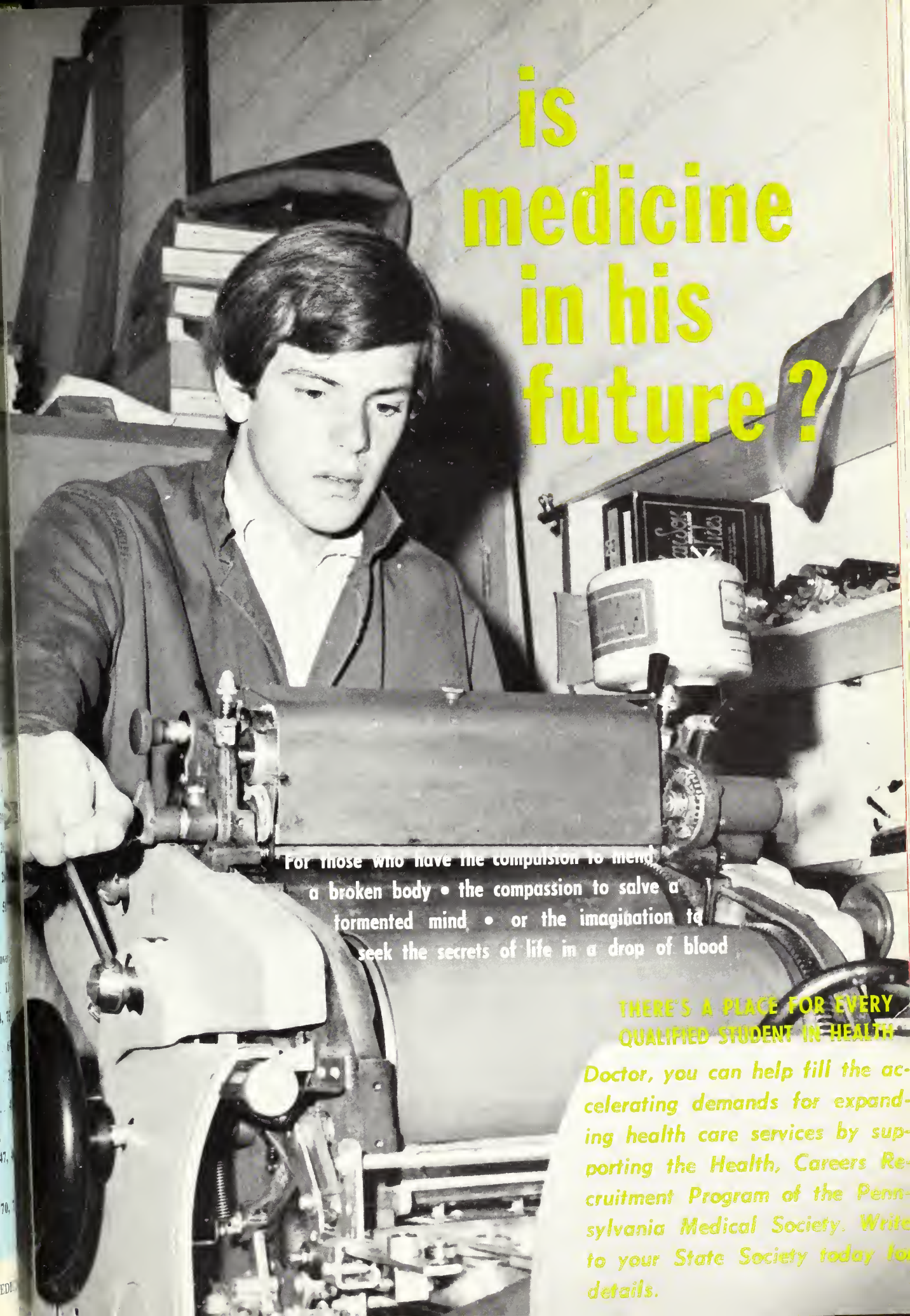

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When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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NOVEMBER 1969

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120th ANNUAL SESSION

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future?
For those who have the compulsion to mend a broken body . . . . . the compassion to salve a tormented mind . . . . . or the imagination to seek the secrets of life in a drop of blood . . . . .
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CAN HELP
THE ACCELERATING DEMANDS
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NOVEMBER, 1969

1969 PMS ROSTER AVAILABLE

Copies of the 1969 PMS Roster, which includes the names of the 12,000 PMS members in alphabetical order throughout the state and in alphabetical order by county with complete, zip-coded addresses, is now available at Society headquarters. PMS members are entitled to a complimentary copy. The cost per copy to non-members or organizations is $10.00. A limited supply is available by sending requests to: Membership Department, Pennsylvania Medical Society, Taylor Bypass and Erford Rd., Lemoyne, Pa. 17043.

PHYSICIAN'S RECOGNITION AWARD BROCHURE TO BE DISTRIBUTED

Pennsylvania physicians will receive this month a brochure titled "The Physician's Recognition Award"--a detailing of information regarding the continuing education award program which was established at the AMA Clinical Convention in December, 1968. The 1969 House of Delegates, in their October annual meeting, endorsed this program and recommended that each member strive for the award. Application for the award is voluntary and any physician in any field of medicine may apply. Practicing physicians may qualify by reporting 150 credit hours of continuing education within the last three years (60 hours of this time must be in a required-credit category). Required credit hours are given for any course sponsored by: 1. An AMA accredited education institution (note: The AMA code in the Continuing Education pages of PENNSYLVANIA MEDICINE indicates courses planned by those Pennsylvania institutions which have been accredited to date); 2. The Council on Education and Science of PMS (including the last four annual scientific seminars); and 3. An institution listed in Continuing Education Courses for Physicians in JAMA (see Pages 759-763, Aug. 4, 1969, edition of JAMA). Pennsylvania physicians can volunteer evidence now of continuing educational efforts that are insuring up-to-date medical care for the citizens of the Commonwealth by completing and returning the Credit Record which will be mailed by the AMA soon.

CIVIL COMMITMENT PROCEDURES TO BE STUDIED

What happens when a potentially dangerous person requires emergency hospitalization at night or on a weekend when court is not in session and the law protects his refusal to be hospitalized? Under the present interpretation of law, the person would be jailed until such time as the court could determine the necessity for hospitalization. In search of a remedy for this problem, a task force will be formed by the Advisory Committee on Mental Health and Mental Retardation, advisor to the Office of Mental Health, DPW, and is scheduled to meet in mid-November to conduct preliminary studies. The ultimate aim is to arrive at new legislation and procedures which would facilitate commitment.

NURSE-PHYSICIAN SEMINAR SCHEDULED

The second statewide Nurse-Physician Seminar entitled "Patient Needs in Pennsylvania" is scheduled Nov. 19, 1969, at the PMS headquarters building, Lemoyne. Among the issues to be discussed are collective bargaining with hospitals and paramedical supervision in the hospital setting.

SPEAKERS' BUREAU MEMBERS TO GAIN DRUG ADDICTION EXPERTISE

Because of the intensifying focus being placed on the problems and solutions of drug addiction by government, social and service organizations throughout the Commonwealth and the subsequent increasing demand for expert speakers on this topic, the PMS Speakers' Bureau, under the chairmanship of Arthur E. Pollock, M.D., Altoona, will conduct a one-day seminar, Nov. 20, 1969, to enlighten bureau members on the drug abuse dilemma. Guests at the seminar will include speakers who are experts on the subject of addiction, including former addicts. New literature from the AMA also will be distributed.

RURAL HEALTH ADVISORY COMMITTEE TO STUDY MANPOWER PROBLEMS

In a renewed thrust to bring more adequate delivery of quality medical care to the rural areas of Pennsylvania, the Advisory Committee on Rural Health of the PMS Council on Public Service and representatives of rural organizations will meet Nov. 6, 1969, at PMS headquarters. They will seek a solution to the rural health crisis in the Commonwealth by sharing ideas with such statewide rural-concern groups as the farmers' associations, health department, veterinary organizations and county extension groups. Chairman of the PMS committee is Ross E. Bryan, M.D., of Warren.

NEW SOURCES OF MANPOWER POTENTIAL TO BE CONSIDERED BY PMS COUNCIL

The PMS Council on Education and Science, at its meeting Nov. 13, 1969, will study the feasibility of placing recently discharged military medical corpsmen in Pennsylvania hospitals as traction technicians and orthopedic, pediatric and laboratory assistants as a step toward resolving some of the Commonwealth's medical manpower shortage problems. The Council also plans to consider greater county medical society involvement in curriculum and course planning at vocational-technical schools in county areas because of the untapped source of health, medical and office assistant manpower potential in those institutions.

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■ **to help restore and stabilize the intestinal flora**

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Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

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Literature on indications and dosage available on request.

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References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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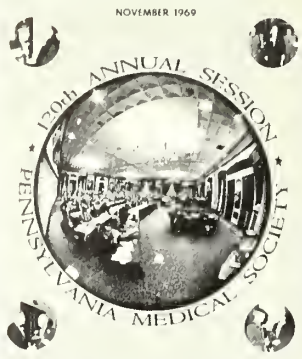

PENNSYLVANIA MEDICINE

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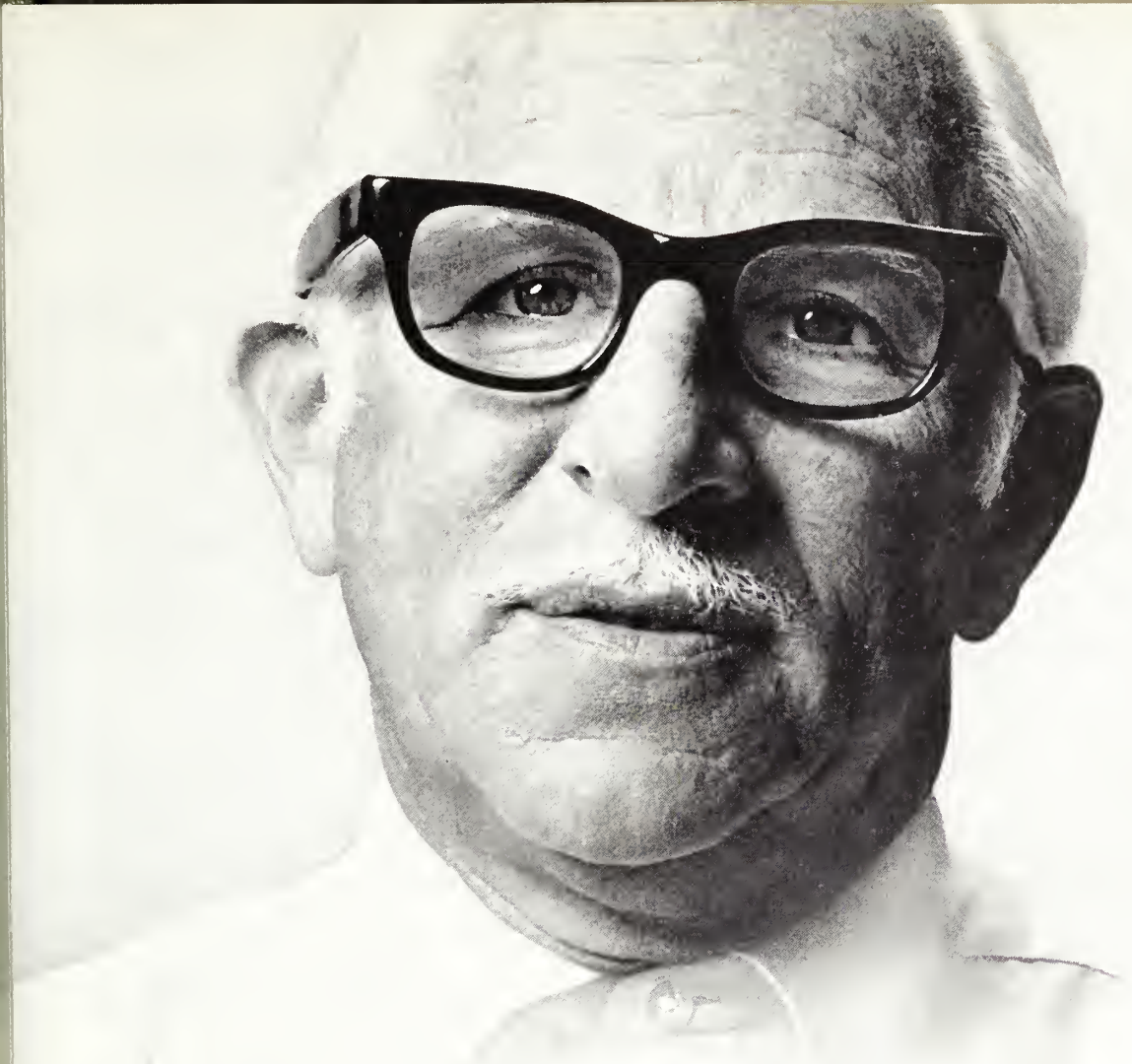

He is elderly.
He is on corticosteroids.
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he may be a candidate for

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Demethylchlortetracycline HCl 300 mg
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Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial light has been observed. Small amounts of drug and short exposure an exaggerated sunburn reaction which may lead to severe skin manifestations. In a smaller number allergic reactions have been reported. Patients exposure to sunlight and discontinue drug if discomfort. Necessary subsequent courses should be carefully observed

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani, maculopapular and erythematous rashes; a rare case of hepatitis has been reported. Photosensitivity; onycholysis of the nails (rare). Kidney—rise in BUN sometimes transient increase in urinary output, some

Hypersensitivity reactions—anaphylaxis (rare).

Teeth—dental staining

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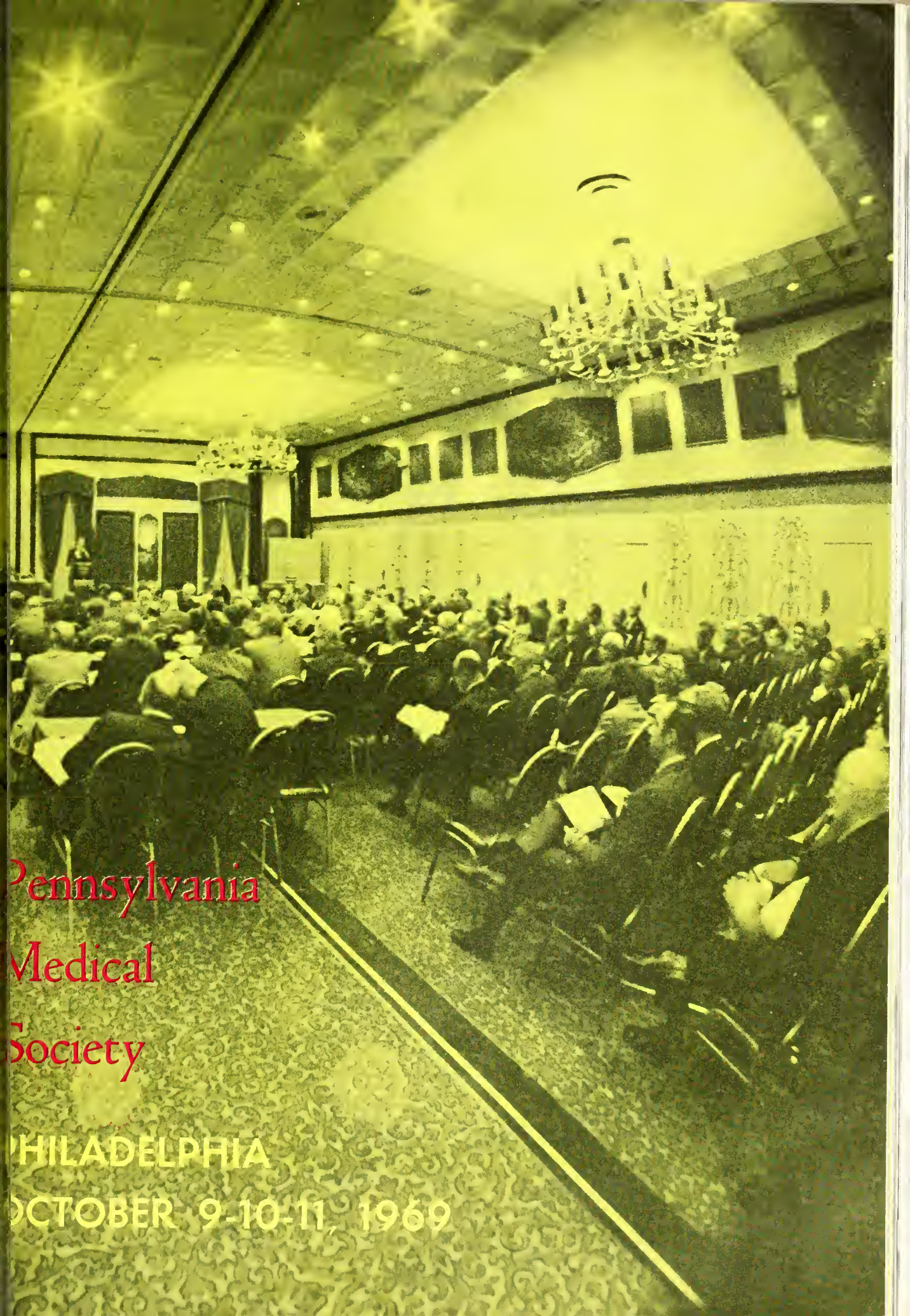

Pennsylvania
Medical
Society
PHILADELPHIA
OCTOBER 9-10-11, 1969

Remarks to the
PMS House of Delegates by

GEORGE E. FARRAR, JR., M.D.

outgoing President of the
Pennsylvania Medical Society

It is customary for the President to thank you for the privilege of serving you. Our Edward L. Bortz, M.D., described his experience as president of the American Medical Association in 1947 to me as "the greatest postgraduate course I ever took." My experience as your president has been equally rewarding. It has been a privilege. I thank you.

Often the president recounts the major accomplishments during the year. This is repetitious and of value mainly for emphasis. The facts are contained in the official reports which each of you has studied in preparation for this annual session. The important accomplishments and failures will be pin-pointed in the reports of the Reference Committees. The interested, competent, industrious members of your Board of Trustees, Administrative Councils, Commissions, Committees and your excellent executive staff perform the work of this Society. As Dr. Harris remarked a year ago, if you forgot to elect a president one year *you* wouldn't miss him, but the *citizens* of Pennsylvania would miss your representative—the voice of 12,000 physician members of the Pennsylvania Medical Society. It would be helpful if each one of you would stimulate at least one non-member physician in Pennsylvania to join each year. I have encouraged all members with ideas and all allied professionals with requests to submit resolutions to this House for consideration. We must increase communications and I shall again urge activation of a lay advisory committee. Your president is your "mouth-piece"; He should also bring to your attention important phenomena of our times. The Chairman of your Board of Trustees and Councilors, William A. Limberger, M.D., does most of the work. Only briefly do I remind you of the great man you have had for thirty-five years as your executive director. We are indeed fortunate to have had Lester H. Perry and we shall express our appreciation to him more fully later. At this time, I shall thank him for hiring and training his most effective successor, John F. Rineman, and the other members of the executive group without whom your Society would be non-functional and your public image would be less pleasant. I thank them for you.

Your recently resigned president-elect, Carl B. Lechner, M.D., had prepared his program for the year. Because of his illness, which deprives you of an exceptional leader, I have requested that his plea for active citizenship be presented to you here and published in PENNSYLVANIA MEDICINE. Please read it. It will do you good; in so far as you act as he requests, it will do the Society good. I wish to address my remarks to the future, to the seventies, namely the "White House Report on Health Care Needs" of July 10, 1969. Ladies and gentlemen, this report is important, in fact essential. Please heed this cry for aid from President Nixon and Secretary Finch. Excerpts from it are as follows:

"This nation is faced with a breakdown in the delivery of health care unless immediate concerted action is taken by government and the private sector. Expansion of private and public financing for health services has created a demand for services far in excess of the capacity of our health system to respond.

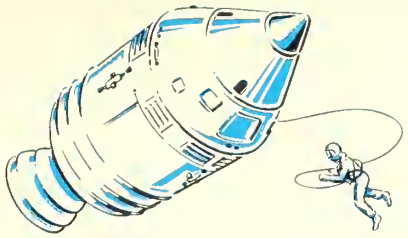
"The result is a crippling inflation in medical costs causing vast increases in government health expenditures for little return, raising private health insurance premiums and reducing the purchasing power of the health dollar of our citizens . . . the Medicaid program has attempted to provide medical services for the poor by pushing them into the nation's already overburdened health care system without developing the capacity in the system to serve them without building the capability in the states to manage the program . . .

"Our overtaxed health resources are being wastefully utilized, and we are not adding to them fast enough to keep pace with rising demand. Our health priorities are critically out of balance.

"Our incentive systems all lead to over-use of high-cost, acute-care facilities, while the need increasingly is for lower-cost alternatives.

"Our task now as a nation is to acknowledge the extreme urgency of the situation, to take certain steps to arrest the inflation that is paralyzing us and put into motion initiatives that ultimately will reshape the system.

"This task is obviously not one for government alone,



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

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For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

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Contraindications: Hypersensitivity to tetracyclines. *Warning:* In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs. *Precautions:* Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

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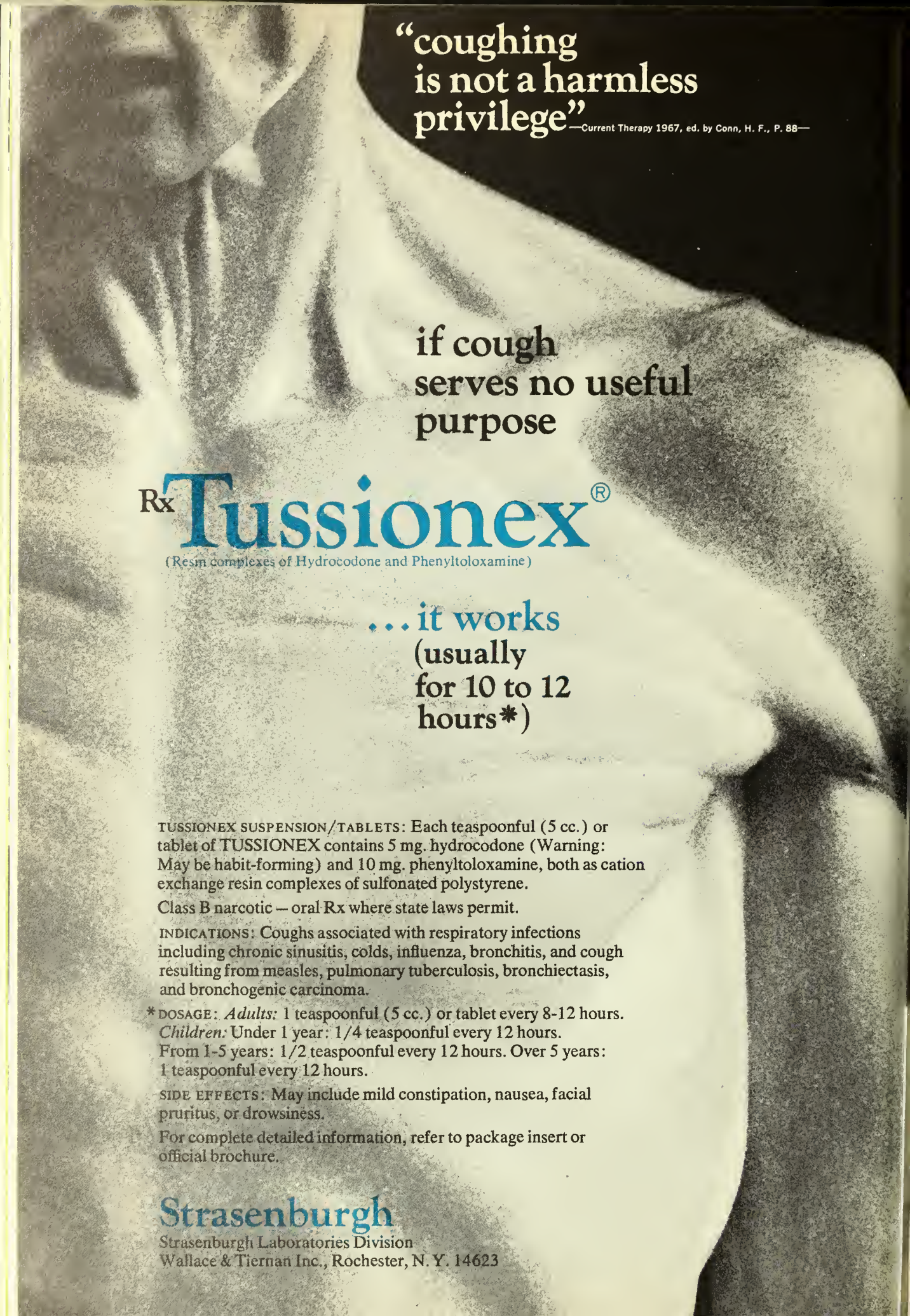
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(Resin complexes of Hydrocodone and Phenyltoloxamine)
...it works (usually for 10 to 12 hours*)
TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.
Class B narcotic — oral Rx where state laws permit.
INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.
*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.
SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.
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although government has a major role to play. Much of the burden must be taken up by the private sector since it has the primary responsibility for the delivery of health care.

"Unless government and our vast array of private institutions can learn to work together we cannot succeed. The fault in the past has been shared by both . . .

"This Administration is committed to correcting these past failures of government and to challenging the private sector to begin the process of revolutionary change in medical care systems . . .

"We are eliminating the allowance to hospitals and nursing homes for unidentified costs.

"We are enforcing regulations limiting payment to individual practitioners under Medicaid.

"We are increasing reviews of drug utilization, drug pricing, drug efficacy and safety.

"We are directing the Public Health Service to promote alternative medical care facilities.

"We are requiring tighter, more frequent reviews of hospital care for patients.

"We are requiring that physicians be identified . . . in all Medicare and Medicaid transactions in order to assist in the audit . . .

"To help alleviate a serious manpower shortage, we are . . . developing programs for returning Vietnam medical corpsmen.

Medicaid burden on general revenues by shifting to various forms of prepayment . . .

"Millions and millions of health care transactions occur every day in which the determining factors are utilization and pricing decisions made by private individuals, by physicians and other professional persons, by industry and labor and by voluntary institutions . . .

"We must insure that the private consumers in these actions receive adequate services at a reasonable price. This requires a major commitment by the varied segments in the private health care industry to drastic changes in the industry . . .

"We will ask and challenge the health insurance industry . . . to provide broader and more effective coverage . . .

"We will ask and challenge the physicians, dentists and other practitioners of the nation through the national societies and through the county associations to establish procedures to review the utilization by their members of various services, to review in particular the use of nursing homes, which now absorb one-third of the $5 billion expended on Medicaid by Federal and state governments, to encourage utilization by their members in all instances to less expensive types of care and to discipline those who are involved in abuses.

"We will ask and challenge the hospitals . . . to review and revise their procedures . . .

"We are proposing legislation . . . to bar from participation practitioners who have consistently abused the program, to . . . engage in incentive reimbursement . . .; to withhold reimbursement for facility expenses incurred contrary to a regional or local plan for health care facilities, and to insure that government does not pay more for services than the charges to the public at large.

"We propose to shift emphasis . . . to the development of facilities for preventive care, outpatient care and to modernization of inner-city hospitals.

"We will move in the direction of reducing the

"We will ask and challenge the deans . . . to find new ways to expand the number of persons they are training . . .

"We will call upon the governors and state legislatures to re-examine and evaluate the role of state health departments . . .

"We will review . . . the role and the performance of federal hospitals, Federal health programs and the future of the commissioned corps of the Public Health Service.

"We will call upon citizens' groups . . . to continue their efforts to hold the medical care industry and gov-

ernment responsible for good management . . .

"We will ask and challenge American business to . . . create new and competitive forms of organization and to deliver comprehensive health services on a large scale . . .

"We are creating a special industry group . . . to provide health education and preventive health care for employees at every level and their families . . .

"Many dedicated persons . . . are already working toward these goals . . .

"What is ultimately at stake is the pluralistic, independent, voluntary nature of our health care system. We will lose it to pressures for monolithic government-dominated medical care unless we can make that system work for everyone in this nation."

Those are the essentials of the report. It merits your attention.

So? The cost of good health care is no longer acceptable to the American public. President Nixon must control costs. This Administration is doing things and will do more to control costs. In 1968, $53 billion was spent for health care in the U.S.A. Of this 60 per cent was private expenditure. The total was 6.5 per cent of Gross National Product in this nation and yet masses of citizens do not have much health care. How much will this nation allocate to health? Formerly, a reasonable average was thought to be 4 per cent of the Gross National Product. Hospitals comprise 40 per cent of the health costs; the cost of operating a bed for acute illness in a general hospital was $18,500 per annum. Nursing homes account for another 20 per cent of health expenditures. The great whipping boys—the pharmaceutical industry and the physicians' fees—introduce only 10 per cent each in the total.

It is helpful to keep these round numbers in mind; hospitals 40 per cent, nursing homes 20 per cent, physicians 10 per cent, dentists 10 per cent, drugs 10 per cent, miscellaneous 10 per cent. The medical, dental and pharmaceutical industries *alone* then can have no significant effect on the total. For instance, if drug costs were decreased by one quarter, or physicians' or dentists' fees were controlled at seventy-five cents on the dollar the change would be only from 10 per cent to 7.5 per cent each of the total and few would be able to find this savings in the complicated financial statements. The hospitals are caught with labor representing 70 per cent of their total costs and vigorous union demands to pay minimum wages for unskilled labor and an increasing need for more highly trained and expensive technical helpers to use our electronic machines. The nursing homes are unable to find help. Ladies and gentlemen, we are in serious trouble! If we don't get together with government (remember 30 per cent of the $53 billion), we shall "hang separately." You and I and our loved ones will be hurt, and the high quality health care of which we are justifiably proud in this nation will be destroyed. Where else in the world can it be reproduced?

The government has challenged the private sector. Government cannot do it alone; the previous Administration tried in vain. Only you, working with the government in our pluralistic system can do it. Organized medicine is expected to be constructive, to improve our civilization in general and its health in particular. We need to hurry!

Doctors *Farrar and Carl B. Lechner deliberate PMS House actions.*

A. HEALTH CONFERENCE

I recommend that the Pennsylvania Medical Society call a meeting at Lemoyne of all elements of the health industry in this state, such as I suggested to the governor in a personal letter last spring. (See Appendix A for outline). I recommend that funds be authorized for a two-day meeting and that this activity be assigned to the Council on Public Service for implementation.

B. PEER REVIEW

I recommend that each District Councilor be responsible for the development of an effective "peer review" mechanism in each county medical society, regarding both cost and quality of health care and for encouraging the development of such a Review Committee in each local hospital and that a report of this situation be made to the Council on Medical Service annually by each District Councilor.

C. SLUMS

I recommend that a subcommittee of the Council on Medical Service develop "guidelines" for the provision of comprehensive health care in urban and in rural slums, encourage the private sector to provide such services and report annually to the House of Delegates on progress with this program.

Further, I wish to update seven recommendations which I made to you a year ago:

D. CONTINUING MEDICAL EDUCATION

Last year I recommended that an average of fifty hours per year of continuing medical education be required to maintain a license as a physician in Pennsylvania. This was referred to the Committee on Objectives for study.

Since the Council on Education and Science has now made enough progress that it is practical for all our members in all parts of our state to have appropriate continuing education courses, I recommend that the Pennsylvania Medical Society request each member to qualify for the American Medical Association Physician Recognition Award—150 hours of continuing education in every three years. A booklet describing the course of study and the application forms are going presently to each member of the AMA. I recommend that each District Councilor be requested to promote this program in his counties and to report annually to this House on the attainment in his District.

"Organized medicine is expected to be constructive, to improve our civilization in general and its health in particular. We need to hurry!"

E. ALLIED PROFESSIONS

I recommend that the Council on Education and Science continue their efforts to increase the number of qualified allied health professionals and their utilization in this state, by liaison with the office of New Careers in the Federal Government and the Joint Commission of Pennsylvania Legislature working on this problem, including the appointment of a subcommittee to instigate a demonstration project utilizing such allied health persons in regions of Pennsylvania without physicians under the direct supervision of a physician in an adjacent region.

F. SPLINTERING

Last year I viewed with alarm the splintering of the professional and civic efforts of organized medicine. The importance of intergrating the American Medical Association with the national specialty medical societies was recognized with the adoption of the Quinn Report by the AMA in July 1969.

As a first step in this direction in Pennsylvania, I recommend that an Interspecialty Council be established to consist of one representative and an alternate appointed by the President, from nominations received from each Medical Specialty Society in Pennsylvania, to meet four times annually (twice in Lemoyne, once in Philadelphia and once in Pittsburgh), the meeting expenses to be borne by the Society except for the traveling expenses of the specialty society representatives, to report annually to the House of Delegates, the chairman of this Council to be elected annually by the members of this Interspecialty Council and the secretary to be the executive secretary of the Society.

G. TERM LIMIT FOR AMA DELEGATES

Last year I stressed the need to involve more physicians in the affairs of organized medicine. Again,

I recommend that a term of two years be established for Delegates from Pennsylvania elected after 1969 to the House of Delegates of the American Medical Association with the privilege of serving three consecutive terms if re-elected, and after an interval of one year to be eligible for an additional three terms.

H. POPULAR ELECTION OF OFFICERS OF PENNSYLVANIA MEDICAL SOCIETY

In a further effort this year to increase interest and participation, I recommend that the president-elect, the four vice-presidents and the secretary be elected thirty days before the annual meeting by secret mail ballot of the entire membership from nominations made by the Trustees, by the House of Delegates and/or by petition signed by twenty-five active members and announced to the entire membership at least sixty days before the annual meeting. (But not of Trustees, who represent a District and should be nominated by their District and elected by the House of Delegates as at present, and not of Speaker, Vice-Speaker, Treasurer and District Censors who are officers of the House of Delegates.)

I. SAMA REPRESENTATION IN THE HOUSE OF DELEGATES

Further, I request your serious consideration of the resolution which I present at the request of Peter L. Andrus, Vice-President of Region 3, SAMA. (See Appendix B).

J. HEALTH PLANNING

Last year I urged the active participation of physicians in local and regional and state health planning activities being financed by government.

Again, I recommend that each county medical society provide its District Councilor with an annual report on the activities of Regional Medical Programs and Comprehensive State Health Planning Committees in its area for presentation to the Council on Medical Service.

K. ADVISORY COMMITTEE ON HEALTH CARE

Last year I urged the appointment in Pennsylvania of an Advisory Committee of non-medical community leaders as suggested by the President of the AMA. This was approved by the House of Delegates and referred to the Board of Trustees for implementation. The programs recommended by your president were not approved by the Board of Trustees. Since I believe that advice from informed laymen increases in importance,

I recommend that the President be directed to appoint an Advisory Committee of nine representative laymen from all walks of life including the urban and rural disadvantaged persons to meet twice a year in Lemoyne and report annually to the House of Delegates and that the expenses of these meetings be authorized. I recommend further that these appointments be approved by the Board of Trustees, that the members of the committee elect their chairman and that the executive secretary of the Pennsylvania Medical Society, or one of his assistants, at his direction, serve as secretary of this advisory committee.

(Appendix A)

PROPOSED GOVERNOR'S CONFERENCE ON HEALTH

Preliminary Outline

Topic: "Better Health for Pennsylvanians"

First Day

9:00 a.m.—Registration

9:30 a.m.—Address by Governor

9:45 a.m.—Comprehensive Health Planning

10:15 a.m.—Break

10:30 a.m.—Panel on Care of Acute Illness, Including Spokesmen for Physicians, Nurses, Hospitals, City Government, Insurance

11:45 a.m.—Question and Answer Session

12:30 p.m.—Lunch; Secretary of Health, Education and Welfare on Role of Federal Government

2:00 p.m.—Panel on Care of Chronic Illness, Including Spokesmen on Geriatrics, Nursing Homes, Convalescent Homes, Occupational Therapy

2:50 p.m.—Question and Answer Period

3:00 p.m.—Break

3:30 p.m.—Panel on Rehabilitation, Including Spokesmen on Physical Medicine, Physical Therapy, State Vocational Rehabilitation, Blindness, Deafness

4:40 p.m.—Question and Answer Period

5:15 p.m.—Adjourn First Day

Second Day

9:00 a.m.—Panel on Preventive Care, Including Spokesman on General Public Health, Divided into Following Segments:

Pediatrics—From Viewpoint of Physicians, School Nurses, Dentists and Psychiatrists

Prenatal—Including Spokesmen for Dept. of Health, Obstetricians, Public Health Nurses

Occupational—Industrial Physician and Industrial Nurse

(Break)

Pollution—State Sanitarian

Veterinary Disease—Veterinarian

Domiciliary Care of Aged—Spokesmen for Private and Public Viewpoints

11:55 a.m.—Question and Answer Period

12:30 p.m.—Lunch; Speaker on Role of Social Security Administration

2:00 p.m.—Summary Panel, Including Spokesmen for the Private and Public Sectors

3:20 p.m.—Break

3:40 p.m.—Plans for the 1970s—State Secretary of Health

4:00 p.m.—Question and Answer Period

4:30 p.m.—Adjourn

(Appendix B)

SAMA REPRESENTATION IN THE HOUSE OF DELEGATES

WHEREAS, the vast majority of today's medical students are responsible, concerned individuals who are more mature and well-informed on the issues than at any previous time; and

WHEREAS, today's medical students have well thought-out and meaningful opinions on the important issues in health care today, and should have an opportunity to express themselves on these issues, and to have their views given serious consideration; and

WHEREAS, the Pennsylvania Medical Society has long sought a means of encouraging young physicians and physicians-in-training to become interested and involve themselves in the affairs of organized medicine; and

WHEREAS, the Student American Medical Association is currently the most representative means through which medical students have been demonstrating their concerns through words and deeds; therefore

BE IT RESOLVED, that medical students shall have full representation in the House of Delegates of the Pennsylvania Medical Society on the basis of one delegate for every hundred, or fraction thereof, active members in good standing of the Student American Medical Association in each of the schools of medicine located within the geographic boundaries of the Commonwealth of Pennsylvania; and further

BE IT RESOLVED, that such delegates shall have the right to vote on all questions, serve on reference committees and introduce resolutions, and shall be elected from the students who are active members in good standing of their respective chapters of the Student American Medical Association; and further

BE IT RESOLVED, that amendments to the Constitution and Bylaws of the Pennsylvania Medical Society necessary to effect this change shall be drafted and presented to the House of Delegates for its consideration and action, and such other steps as may be necessary to effect the intent of this resolution shall be taken as rapidly as possible; and further

BE IT RESOLVED, that the Pennsylvania Medical Society shall support efforts to effect similar changes in the Constitution and Bylaws of the American Medical Association so as to provide for medical student representation on a voting basis in the House of Delegates of that organization.

In the Saddle

Participating *in the opening session of the 1969 PMS House of Delegates are (left to right) William A. Limberger, M.D., West Chester, PMS president-elect; George E. Farrar, Jr., M.D., Philadelphia, immediate past-president, PMS, and William A. Barrett, M.D., Pittsburgh, PMS president.*

PMS Officials Elected, Re-elected

Pittsburgh Urologist Installed As President

William A. Limberger, M.D., West Chester, was elevated from the chairmanship of the Board of Trustees of the Pennsylvania Medical Society to the office of president-elect in one of a series of elections at the PMS Annual Session in Philadelphia, October 11.

The Medical Society's House of Delegates chose Dr. Limberger, a specialist in internal medicine with wide experience in medical society affairs, to succeed to the presidency a year from now.

William A. Barrett, M.D., Pittsburgh, was elevated, October 10, to the presidency following a special election held because of the ill health and resignation of the 1968-69 president-elect, Carl B. Lechner, M.D., Erie. Retiring president is George E. Farrar, Jr., M.D., Philadelphia.

The PMS Board of Trustees, at its reorganization meeting following the last session of the House, elected Park M. Horton, M.D., New Milford, new chairman of the Board.

In other voting, the delegates from the state's component county medical societies elected Raymond C. Grandon, M.D., Harrisburg, as secretary to succeed A. W. Cowley, M.D., of the same city.

Four vice-presidents were elected: Charles K. Rose, Jr., M.D., Allentown, first vice-president; Charles A. Bikle, M.D., Chambersburg, second vice-president; Orlo G. McCoy, M.D., Canton, Pa., third vice-president; and Edward T. Lis, M.D., York, fourth vice-president.

William Y. Rial, M.D., Swarthmore, and John B. Lovette, M.D., Johnstown, were re-elected speaker and vice-speaker, respectively, of the House of Delegates.

William F. Brennan, M.D., Pittsburgh, was re-elected to the Society's Judicial Council.

LeRoy A. Gehris, M.D., Reading, and David J. Keck, M.D., Fairview, Erie County, were elected new members of the Board of Trustees and two incumbent board members—A. Reynolds Crane, M.D., Philadelphia, and H. Thompson Dale, M.D., State College—were re-elected.

Six physicians were elected to serve two-year terms as delegates to the American Medical Association House of Delegates. They are Samuel B. Hadden, M.D., and Malcolm W. Miller, M.D., Philadelphia; Wendell B. Gordon, M.D., Pittsburgh; John B. Lovette, M.D., Johnstown; Thomas W. McCreary, Sr., M.D., Rochester, Beaver County; and Russell B. Roth, M.D., Erie, who is current speaker of the AMA House of Delegates. Eight physicians were elected to fill vacancies as alternate delegates to the AMA. They are R. William Alexander, M.D., Reading; Paul S. Friedman, M.D., and R. Robert Tyson, M.D., Philadelphia; John F. Hartman, Jr., M.D., and Carl B. Lechner, M.D., Erie; Wilbur E. Flannery, M.D., New Castle; Matthew Marshall, Jr., M.D., Pittsburgh and David S. Masland, M.D., Carlisle.

John B. Montgomery, M.D., Philadelphia, was re-elected as a member of the Committee to Nominate AMA delegates and alternates.

Journal to Publish Full Proceedings

This issue of PENNSYLVANIA MEDICINE contains news and pictorial highlights of the 1969 Annual Session of the Pennsylvania Medical Society which includes reports on actions taken by the House of Delegates of immediate interest. Publication of the full Proceedings of the House of Delegates will be published in a subsequent issue of the State Medical Journal as will the addresses given at the Socio-Economic Seminar on Comprehensive Health Planning and Professional Corporations held during the Session.

Medicine's Doors Open To Osteopaths

Fully licensed doctors of osteopathy in Pennsylvania may become members of the State Medical Society provided that they are accepted by county medical societies as the result of action of the 1969 PMS House of Delegates which approved changes to the Constitution and Bylaws.

The reference committee recommending the action to the House stated "that it paves the way for each county society to take whatever action it may desire with regard to admission of osteopathic physicians." The AMA took similar action in July.

The approved reference committee report noted that the State Board of Medical Education and Licensure had acted to allow graduates of colleges of osteopathy to be admitted to rotating internships provided that they apply within five years of the date of graduation, and the Board action further noted that upon satisfactory completion of the rotating internship, they may apply for approved residency training in the various disciplines currently approved by the AMA.

However, the reference committee report said: "We recognize that many of the specialty examining boards do not admit osteopaths for examination. We are also cognizant of the many hurdles to be overcome before a truly meaningful relationship between the families of organized medicine and osteopathy can occur.

"We wish to emphasize the importance of continued effort by both parties to achieve the cooperation needed to produce the best possible medical care for our citizens."

The specific changes in the constitution and bylaws merely redefined the term "physician" to mean "a person holding an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania." Similar changes will be required in the constitution and bylaws of county medical societies before membership for osteopaths can be achieved and such changes and any subsequent membership action obviously is at the discretion of each county medical society.

Pennsylvania Second in Nation

Representatives *of the Student American Medical Association (SAMA) were active and interested guests at House sessions.*

Students Accorded House Vote

In a historic action that makes Pennsylvania the second such state in the nation, the PMS House of Delegates changed the constitution and bylaws to provide the president of each Student American Medical Association (SAMA) chapter in the Commonwealth with a seat in the PMS governing body, including the right to vote, serve on reference committees and introduce resolutions.

There are SAMA chapters at each of the seven medical schools in Pennsylvania and the action thus increases the House membership by seven.

In a related action, the House rejected a proposal calling for proportional representation of SAMA chapters in the House of Delegates in ratio of one delegate for each 100, or fraction thereof, of active members in good standing of SAMA.

The amendments establishing SAMA representation in the House set up special student members who are not required to pay any annual assessment. Certain participation for the special student members is excluded (They may not serve on the Reference Committee on Constitution and Bylaws and they shall not have the right to hold any office or to be a member of any council, commission or committee). If the SAMA presidents are unable to serve, they may designate an alternate from the active membership of the SAMA chapter.

Colorado is the only other state in the nation, to date, which has seen fit to incorporate medical student membership in its state medical society.

The House also approved a reference committee report dealing with the involvement of SAMA representatives in the meetings of various State Society councils. Representatives have been invited to attend Council meetings as guests of the State Society so that they might get a better idea of how the Society functions.

Blue Shield, Blue Cross House Actions

The 1969 session of the PMS House of Delegates took action on a number of issues involving the Blue Shield and Blue Cross plans.

The House adopted a slightly amended resolution calling on the State Society to recommend to Blue Cross of Greater Philadelphia and Pennsylvania Blue Shield that action be taken promptly to establish "realistic, up-to-date standards of reimbursement, through Blue Shield, for radiologic services and that these be equally available to all radiologists."

The prelude to the resolution noted that there are inequities in the present reimbursement of different radiologists in different situations for comparable procedures.

The House complimented the Council on Medical Service for the effective implementation of the 1968 resolution calling on Blue Shield to offer the prevailing fee program to all group and non-group subscribers. The Council report had noted that at the time its report was written, Blue Shield was seeking the permission of the Insurance Commissioner to offer the prevailing fee program to non-group subscribers.

In other action, the PMS House of Delegates rejected Resolution 69-3 calling on Blue Shield to completely disassociate itself from Blue Cross. The House said: "'While realizing that ideally, complete separation of Blue Shield and Blue Cross seems desirable, this resolution seems impractical. It would lead to increased costs which would have to be borne by subscribers and these costs would not bring about improvement in patient care."

In rejecting a resolution which called on the State Society to recommend that Blue Shield develop mechanisms to cover all out-patient fees, the PMS House said that "since Blue Cross is not paying outpatient fees and Blue Shield has mechanisms in existence which do pay outpatient fees, this resolution seems inappropriate."

Efforts to have Blue Cross stop the practice of paying physicians' fees and calling on Blue Shield to establish procedures which would place all physicians' fees under their plans were part of two resolutions adopted by the House of Delegates in reversing a reference committee recommendation.

One of the adopted resolutions was more specific in that it sought to have Blue Shield develop a comprehensive fee schedule for radiologic professional services to be paid through all Blue Shield contracts. It further seeks to have the Blue Cross plans in the state discontinue the payment of physicians' fees to hospitals. To implement this, it suggests that the Insurance Commissioner be requested to grant a decrease in Blue Cross rate schedules and to increase Blue Shield rate schedules correspondingly.

The House also adopted a substitute resolution to take the place of four resolutions concerned with the development of Blue Shield payments for multiple consultation services.

The approved reference committee report noted that "because of cost implications, it does not seem suitable that Blue Shield be requested to develop coverage for consultation services in all of its plans."

After considerable discussion, the House adopted the following substitute resolution: "Resolved, that the Pennsylvania Medical Society request the Medical Service Association of Pennsylvania to review its current consultation program to explore the feasibility of providing adequate coverage for multiple consultation."

A resolution which would have called on Blue Shield—should it issue coverage for the services of any non-physicians—to make such coverage payable only when the services are prescribed or ordered by a physician and rendered under his direction, was rejected by the House.

The House-approved reference committee report noted that it "agrees with the intent of the resolution but it believes that effective implementation might provoke public reaction against physicians."

Love People

"Effective public relations can best be accomplished by the individual physician in his daily contact with patients and the public in general," has been a recurring thought of the Council on Public Service which was approved and reaffirmed by the 1969 House of Delegates.

This year, the contention of the Council is further supported by a statement by A. Reynolds Crane, M.D., Philadelphia, who maintains that "What the medical profession needs is more physicians who love people."

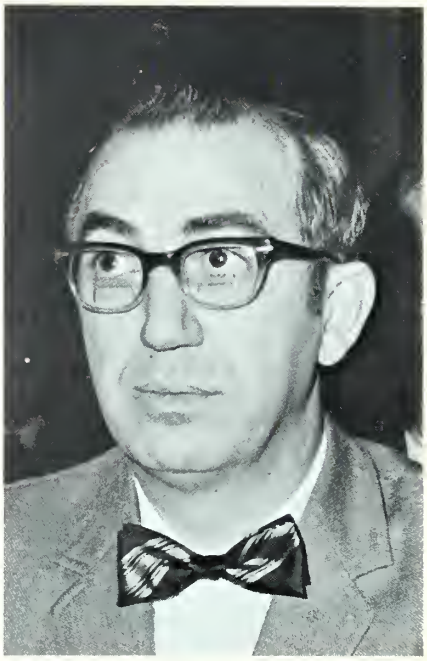
Pennsylvania Blue Shield *guests included (left to right) G. Donald Jenkins, vice president-claims; Matthew K. Gale, president, and Robert E. Rinehimer, senior vice president.*

Rush Awards Presented

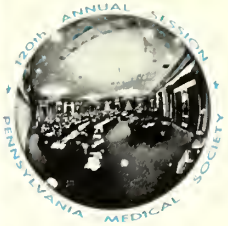
1969 PMS Benjamin Rush Awards *are presented at Annual Session by R. William Alexander, M.D., Reading (left), chairman of the Society's council on public service. Receiving the awards are (2nd left to right) Mrs. Gerald F. Selders, State College, president of the State College Junior Woman's Club—organization award for raising more than $37,000 to improve community health and welfare; Nicholas Dutko, Bethlehem—individual award for outstanding efforts in collecting more than 6,000 pints of blood at his own expense for other health activities; and 15-year old Michael Eller, Oxford—special award for his summer vacation efforts to raise funds for muscular dystrophy victims and $9,000 to purchase an artificial kidney machine for a 10-year old neighbor girl.*

Air Pollution Attacked

The House amended and passed a resolution (69-17) calling for stronger action to control air pollution in the state. The approved reference committee report said that the State Society has been one of the leaders in the fight to gain more adequate air pollution control legislation "and should continue to do so." The only amendment to the resolution corrected the name of the State Society body concerned with air pollution so that the resolution asks that the PMS Commission on Environmental Health keep State Society members informed about the goals pending in the field of air pollution control so that the physicians may send letters of strong support for appropriate legislation to members of the legislature. The resolution also directed the State Society to initiate and support "sound measures to reduce current air pollution, at least to such levels as are and will be set forth as criteria by the federal government." In considering the resolution, the House noted that the Commission on Environmental Health had suggested support of the Senate bill which would add a physician to the state's Air Pollution Control Commission, "which would seem to be a partial answer to getting medicine's views into the air control activity at the state level."



Raymond C. Grandon, M.D., *Harrisburg, was elected new secretary of the Society.*



"Contact Doctor" System Urged

The PMS House of Delegates urged county medical societies to cooperate in the effort to establish an optimum "contact doctor" system designed to make available to each legislator the advice of a physician.

The approved report of the Reference Committee on Governmental Relations said that the legislative information and contact program of the State Society "is still not near its optimum." It noted that the 1968 reference committee had suggested that the Council look into this matter with a view to remedying it.

The report continued by saying that testimony taken at the hearing indicates that much information is being disseminated to county societies, but comparatively little action seems to ensue.

In commenting on the "contact doctor" system, the reference committee pointed out that such major efforts are being conducted in selected areas of the state where a majority of the representatives from these areas are represented on House and Senate committees with which medicine must work.

It continued: "The efforts thus far have been productive, but your committee feels that they are not as productive as they might be if all physicians who have personal friends in the legislature cooperate."

Sole Arbiter Position Reaffirmed

The PMS House of Delegates adopted a resolution which put the House on record as disagreeing with the PMS Judicial Council's decision relating to the right of an individual physician to be the "sole arbiter" of the disposition of his professional income.

(See ARBITER, Page 30)

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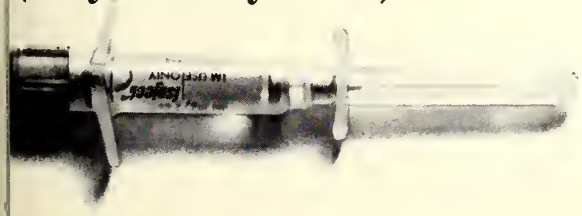
Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

Contraindicated: In individuals hypersensitive to any of the components of this drug.
Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.
Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.
Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.
During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.
Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.
Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.
As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.
The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.
Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.
Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.
Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.
Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.
In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.
In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.
In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.
Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.
Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.
Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.
More detailed professional information available on request.

this ulcer did not heal...until its surface was cleared of dead tissue and debris

FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.

to aid in debridement
to facilitate healing
in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

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Mental Health Action Taken

Three resolutions calling for a separate State Department of Mental Health were successful in modifying the Pennsylvania Medical Society's position when they resulted in the House adopting a substitute resolution which says that a separate Department of Mental Health/Mental Retardation —established under the direction of a qualified psychiatrist—"would best serve the needs of this program."

However, the adopted resolution did describe as "an acceptable alternative to a separate department" the "umbrella" concept of a Department of Human Services with separate and equal offices for health, welfare and mental health.

In addition, the Council on Governmental Relations was directed to undertake action to insure that whatever governmental administrative arrangement is made, the state's mental health and mental retardation programs obtain the freedom they require within the political system.

At the 1968 session of the PMS House of Delegates, the House had rejected a resolution calling for the State Society to work for the establishment of a separate Department of Mental Health. Mental health now is a division of the Department of Public Welfare.

As reasons for the new State Society position, one of the introductory portions to the adopted resolutions points out that "the size and complexity of the mental health/mental retardation program, with nearly one-third of all Commonwealth government employees, indicate that it not be submerged in any other department."

It said that studies by the Pennsylvania Mental Health Association show a marked nationwide trend toward independent departments of mental health and retardation, especially among the major industrial states, with only twelve states still retaining mental health within public health departments.

It said further that passage and initial implementation of the Comprehensive Mental Health/Mental Retardation Act of 1966 has resulted in a great expansion of mental health activities in Pennsylvania and that there is an urgent need to place "the unique problems of implementation in the forefront of the activities of the Commonwealth."

John L. Steigerwalt, M.D., *Rosemont, addresses physicians from Montgomery, Berks, Bucks, Chester, Delaware and Lehigh counties during the meeting of the Second Councilor District.*

Specialty Vote Denied; New Group Approved

A committee of physicians officially representing all specialty organizations in the state will be established by the Pennsylvania Medical Society as the result of a resolution and a recommendation by George E. Farrar, Jr., M.D., approved by the PMS House of Delegates.

At the same time, the House rejected two resolutions which called for each established medical specialty in the state to have a voting delegate in the House of Delegates.

The committee to be established will be known as the "Interspecialty Committee" and it will be charged with the responsibility of reviewing policy, socio-economic matters, legislation and other subjects affecting specialty practices and the relationship between specialty organizations in the State Society. The committee will consist of physician-members nominated by their respective specialty societies and appointed by the State Society president.

William B. West, M.D. *(left), Huntingdon, chairman of the Pennsylvania Medical Political Action Committee, presents a honorary life membership certificate to Stephen F. Deichelmann, M.D., in recognition of dedicated service to PAC activities.*

Hospital Boards Should Have M.D.'s

Physician membership on hospital governing boards was the subject of two resolutions considered by the House of Delegates which, instead, adopted a substitute resolution to meet the same intent.

The adopted resolution resolves that the Pennsylvania Medical Society recommend to the governing boards of Pennsylvania hospitals, the Hospital Association of Pennsylvania, and the various hospital councils in Pennsylvania that governing boards of accredited Pennsylvania hospitals have adequate representation of physicians with voting privileges.

It further resolved "that such physicians be appointed by the boards from nominees suggested by the medical staff."

The final portion of the resolution resolved "that the Pennsylvania Medical Society recommend to the AMA representatives to the Joint Commission on Accreditation the requirement that one or more representatives of the medical staff of the hospital be named as voting members to the board of directors."

PMS

The PMS House of Delegates paid tribute to Mr. Lester H. Perry upon his retirement as executive director of the State Society after thirty-five years of service in a number of separate actions during the House sessions and in a special portion of the program at the State Dinner.

Mr. Perry officially retired as executive director upon adjournment of the 1969 House but he will continue to serve the State Society in an advisory capacity.

The Board of Trustees at its reorganization meeting following adjournment of the House officially designated Mr. John F. Rineman, who has been assistant executive director, as the executive director of the State Society.

The October 1969 issue of PENNSYLVANIA MEDICINE was dedicated to Mr. Perry and contained various articles concerning him, his work and his family. An article about Mr. Rineman, the new executive director, appears on page 37.

The special portion of the State Dinner program honoring Mr. Perry included the presentation of: service awards and of a silver tray engraved with the signatures of the members of the Board of Trustees and officers of the society; a gift from the Woman's Auxiliary; book of letters from friends and fellow medical society executives throughout the nation; and a plaque from the staff.

Mr. Perry's remarks in response to the gifts and comments appear below.

As part *of the state dinner program, service recognition plaques were presented to retiring Trustee and Councilor James A. Biggins, M.D., (above) of Sharpsville and to Allen W. Cowley, M.D. (right) of Harrisburg, who chose not to be a candidate for reelection as secretary.*

Remarks of

LESTER H. PERRY

Retiring PMS Executive Director

My reaction tonight is basically the same as it was one evening last May when the Dauphin County Medical Society presented me with a plaque. As I told that group, many people have asked me over the years if I were a doctor. When I told them no, they sometimes asked if I ever wanted to be a doctor. My answer to that question was also in the negative and for a very simple reason. I don't think I have the mental and emotional equipment to be a good physician. Consequently, when I am the recipient of gifts and tributes such as I have received this evening from members and other representatives of a profession whose qualifications I am unable to meet, I feel not only deeply grateful but also very humble.

The process of retiring is rather interesting if you don't take it too seri-

22nd Annual State Dinner

ously. People become so very gracious. By both the spoken and the written word, they magnify your virtues and minimize your faults. Frankly, one of of the most difficult tasks is to keep from believing every detail of what is said about you. But these comments—I must confess—are pleasant to hear, and what happens comes about as close as anything I can imagine to the unique experience of attending your own memorial service.

So many generous remarks have been made about me in recent days that I hardly know what to say in response. I'm afraid that I have become too enchanted with this rhapsody of words to make the appropriate denials. If I have achieved any measure of the success attributed to me, however, I would like to take this opportunity to tell you the reasons why.

When the starting gun sounded in 1934 and I began this thirty-five year marathon, my coaches were Dr. Moses Behrend, president; Dr. Alexander Colwell, president-elect; Dr. Edgar Buyers, chairman of the Board; and Dr. Walter Donaldson, secretary of the Society. Those among you who knew these men personally will realize that—under their guidance—I had to get off to a good start.

This year—as I came down the home stretch—once again my coaches were outstanding: George Farrar, president; Carl Lechner, president-elect; Bill Limberger, chairman of the Board; and Clem Cowley, secretary. With these fellows directing my efforts and cheering me on, how could I help but make a strong finish?

In the intervening years, the story has been the same—superb direction by capable leaders. I regret that time

Biographical Profile - Lester H. Perry

To Remain As Consultant

Lester H. Perry, a Pittsburgh native and former assistant dean of men at the University of Pittsburgh, retired Oct. 11 as executive director of the Pennsylvania Medical Society after thirty-five years of service.

His career in organized medicine started in 1931 when he resigned as assistant dean of men at Pitt to become the first executive secretary of the Allegheny County Medical Society. Three years later, he joined the staff of the Pennsylvania Medical Society—the third largest in the nation—and moved to his present home in the Harrisburg suburb of Lemoyne.

Mr. Perry was one of the nine original incorporators of the Medical Service Association of Pennsylvania—Blue Shield—and served as its unpaid executive director in addition to his duties with the State Society for seven years starting in the late 1930's. He was elected secretary of Blue Shield at its first meeting and has continued to serve in that capacity for the more than twenty-nine years since. He also has been a member of the Blue Shield Board of Directors for the same period except for a one-year interval.

Mr. Perry's successor was the Society's assistant executive director, John F. Rineman of Hershey.

Although retiring as executive director, Mr. Perry remains with the State Society as a consultant on financial and special problems.

Mr. Perry was born in Pittsburgh on June 13, 1904. His father was a machinist for the Jones and Laughlin Steel Corporation and he was the eldest of three sons and two daughters. He started out in the College of Liberal Arts at Pitt, transferred as a junior to the School of Education and was awarded his A.B. degree in 1925. He was a teacher at McKees Rocks High School for two years before returning to Pitt as assistant dean of men for four years.

Mr. Perry and his wife, the former Margaret Knowlson of Pittsburgh, have two children, Mrs. Alfred L. LeVan of Gettysburg and John, at home.

Remarks of Lester H. Perry / Continued

does not permit me to mention all of them. And because I can't mention all, I can't mention any, for—if I started I wouldn't know where to stop.

One of my coaches during the home stretch has occupied a unique position in this organization for many years. He is not only an active member of the Society, serving in many important capacities, but in a certain sense he is also a member of the staff. At least, his position as medical editor of PENNSYLVANIA MEDICINE has brought him into close contact with the administrative affairs of the Society. Because of this contact without the necessity of his personal involvement in management decisions, Carl Lechner became both knowledgeable and objective about administrative problems. Recognizing that these characteristics form the basis for sound judgment, I did not hesitate to seek Carl's advice and counsel, and I want to express my appreciation to him for his helpful guidance.

The outstanding leadership I have always received from the officers and trustees was complemented by the earnest helpfulness of the Woman's Auxiliary, the cooperation of council, commission, and committee personnel, and the unfailing support of the House of Delegates. For all these blessings, I am grateful.

Tomorrow the World Series begins, and the toast of baseball fans everywhere are the "Amazing Mets" and their manager—Gil Hodges—who recently wrote a book with this prosaic title: "The Game of Baseball."

When asked by one of his friends why he didn't use a more imaginative title like, "How to Be a Winning Manager," Mr. Hodges replied that such a book would be too short because he could say everything he knew about how to be a winning manager in one sentence: "Have the right players; otherwise, forget it."

The first manager of the New York Mets—Casey Stengel—is the outstanding example of the point made by Mr. Hodges. He began his career as a manager in the National League—three years at Brooklyn and six years at Boston. In those nine years none of his teams ever finished in the first division—fifth place was the highest. In 1949 Casey began a twelve year reign as manager of the Yankees, during which he won ten pennants and seven world championships—the most successful record of any manager in baseball. In 1962 Mr. Stengel returned to the National League as the first manager of the Mets, and they lost more games than any other team in history. He continued to manage them for three more years, and they finished in the cellar every time.

The Casey Stengel who had such a brilliant career with the Yankees is the same Mr. Stengel whose record in the National League was so disastrous. Only the players were different, but what a difference they made!

What Gil Hodges said about baseball applies to managers in any field of human endeavor. No manager can do a good job without capable and conscientious members on the team. The ability, the self-sacrifice, and the cooperation of the men and women who have worked with me constitute the priceless ingredient necessary to the success of your administrative team. To every one of them I express my sincere appreciation.

And now one final word. In order to cope with the problems of the workaday world, I happen to need both the inspiration and the solace of a happy home. And I am fortunate that Jane and Johnny and especially their Mother have provided me with such a haven. To each of them goes my deepest gratitude for their love and encouragement.

As I bring to a close not only these inadequate remarks but also a career which has been rewarding because it has given me the opportunity to serve a great and noble profession, I am reminded of an observation made by Sophocles twenty-four centuries ago when he said,

> "One must wait until evening to realize how splendid the day has been."

Abortion Stand Reaffirmed

A resolution concerning a stand on therapeutic abortions was rejected by the PMS House of Delegates as too restrictive.

The House subsequently reaffirmed its 1967 action which called on the legislature to adopt model legislation in this area.

The 1967 House action came after consideration of a crimes code bill then before the legislature and it made only minor suggestions for modifications in that legislation.

Briefly, the 1967 stand would permit therapeutic abortions if there is risk that continuance of the pregnancy would gravely impair the physical and mental health of the mother, if there is substantial risk that the child will be born with grave physical or mental defect, or if the pregnancy resulted from statutory or forcible rape or incest.

Usual Fee Action Urged

There is "no indication that any progress has been made" in establishing usual and customary fees under the Pennsycare program, according to a statement made by the House of Delegates in its consideration of the annual reports of the Council on Medical Service.

The House urged the Council "to be more rigorous in pursuing this objective since there appears to be a developing sentiment among legislators to embrace fixed fee schedules for payment of physician's services."

Medical Staff Rights Studied

Introduced by the Montgomery County Medical Society, the PMS House of Delegates adopted a resolution designed to have the AMA Judicial Council update guidelines concerning the relationships between hospital boards of directors and their respective medical staffs.

The resolution noted that there is evidence of the growing trend by hospital board of directors to change the "traditional relationship" which has existed between them and the medical staff.

The resolution also pointed out that the PMS Judicial Council has ruled that it is a violation of the principles of medical ethics to remove from the medical staff the responsibility to recommend appointments and reappointments to the staff and the resolution asks that the State Society instruct its delegates to the AMA to introduce a resolution to that body calling upon the AMA to include the PMS Judicial Council guidelines under the AMA principles of medical ethics.

Umbrella Insurance Study Directed

The PMS House of Delegates adopted a resolution which calls on the AMA House of Delegates to appoint an insurance committee to study the practicability, cost, protection and feasibility of an "umbrella type" insurance coverage for all members of the AMA.

Comments preceeding the resolution noted that the cost of malpractice insurance has increased markedly but that all physicians have need for insurance coverage such as health, accident, life, liability, fire, theft, car and retirement plans.

The House therefore proposed that the group plan to provide all types of insurance should offer considerable savings.

Staff Rights Defined

A resolution expressing concern about the reasons that some physicians may be denied hospital staff appointments resulted in the resolution being amended and passed.

The resolution stated that "every physician, salaried or in private practice, be given privileges consistent with his abilities as judged by the broad base of his peers, the members of the hospital staff."

The resolution noted that the denial of hospital staff privileges sometimes impairs the patient's right to his choice of physician.

In the House discussion concerning the resolution, it was noted that it is almost impossible to measure the performance of a physician who does not have hospital privileges.

Ambulance Training

All county medical societies in the Commonwealth were urged to assume the responsibility of helping to update annually the first aid instruction of all ambulance attendants operating in their areas in a resolution adopted by the PMS House of Delegates.

On the same subject, the reference committee noted that the PMS Advisory Committee on Emergency Medical Service is participating in the development of curricula and teaching procedures for the training of ambulance attendants and in the establishment of minimum standards for ambulance equipment.

The advisory committee said that "physician teaching . . . is absolutely essential so that proper procedures and methods can be developed and utilized" by ambulance personnel.

County Staffs Supported

The House of Delegates approved a reference committee report which noted that there is only limited implementation of State Society activities on the county level because many county societies do not have the services of an executive secretary.

The report said, "to provide desirable services to both physicians and the public, the reference committee feels that it is wise to have staff services universally available.

The reference committee noted the many barriers to such a universal service and it endorsed a recommendation made to the Board of Trustees and Councilors by the Council on Public Service which calls on each Trustee and Councilor to evaluate the need for staff services in his district.

ARBITER / from page 20

At the same time, it postponed indefinitely action on a resolution related to the same subject and to the establishment of special hospital funds.

The introduction of the approved resolution noted that the 1967 House of Delegates had passed a resolution stating that an individual physician may not be deprived of his right by a vote of a medical staff or medical board of a hospital to be the "sole arbiter" of a disposition of his professional income.

It then noted that the PMS Judicial Council, in an opinion rendered after a hearing in Philadelphia earlier this year, said, "IT IS ethical for a medical staff to adopt a resolution which requires all members of a staff to donate a percentage of third party payments to a hospital fund, educational fund, teaching fund, etc. . . ." And in the same opinion, it added, "It is important, also, to remember that your Council continues to recognize that the physician is, in the final analysis, the sole arbiter of his income, for, if a physician is unwilling to support such a fund when same is established by a majority vote of the medical staff, he can, as a matter of absolute right, relocate . . ."

The resolution adopted at the 1969 session of the House affirms the 1967 resolution and resolves "that the House of Delegates of the Pennsylvania Medical Society disagrees with the Judicial Council's interpretation of the AMA guidelines as they pertain to the right of the individual physician to be the sole arbiter of the disposition of his professional income; and be it further resolved, that the House of Delegates, Pennsylvania Medical Society, strongly recommends that the Judicial Council reconsider its interpretation of these guidelines and issue its opinion at the earliest possible date."

Matthew B. Marshall, M.D., *Pittsburgh, addresses the House of Delegates during floor debate.*

The House *accorded the floor to Robert Slama, Temple University School of Medicine SAMA chapter representative who outlined the reasons for the recent nationwide Vietnam "Moratorium Day."*

Reinstatement of Delinquent Members

The PMS House of Delegates approved changes in the Bylaws of the Society clarifying the procedure involved in the reinstatement of a member who is delinquent in paying his annual assessment.

The changes clearly establish the reinstatement of the delinquent member by his county medical society as the key to his return to good standing in the State Society.

The reference committee "noted with interest" the practice of the Berks County Medical Society in requiring approval of the county board of censors before a delinquent member is reinstated to good standing.

The reference committee said "because such a procedure reflects favorably in organized medicine's determination to keep order in its own house, we view with approval this procedure."

The change in the Bylaws makes it clear that reinstatement is not automatic upon payment of back dues but that it is subject to reinstatement by his component society.

Hypnosis Position Adopted

The House of Delegates adopted a statement on hypnosis proposed by the Commission on Mental Health of the Council on Education and Science which declared that hypnosis is a specialized procedure that appropriately could be limited to being an adjunct to research, to diagnosis and to treatment in health care.

The commission recommended that any other use, such as in entertainment, should be prohibited by law because the dangers involved in the indiscriminate use of hypnosis may lead to psychosis, economic and personal exploitations, suicidal and homicidal behaviors, physical disorders, and other pathological conditions of the person.

"Whoever makes use of hypnotic techniques, therefore," stated the resolution, "should have sufficient knowledge of psychiatry, and particularly psychodynamics, to avoid its use in clinical situations where it is contraindicated or even dangerous. For hypnosis to be used safely, even for the relief of pain or for sedation, more than a superficial knowledge of the dynamics of human motivation is essential."

PMS Dues Remain $75.

The House of Delegates approved retaining the current $75.00 annual dues for active membership in the State Society, allocated $8.00 from each active member's dues to the Educational Fund of the Educational and Scientific Trust, and allocated $1.00 per active member to the Medical Benevolence Fund.

William J. Putnam, D.D.S., *assistant surgeon general, regional health director, Region II HEW, addresses guests at a Socio-Economic*

The recommendation for retention of current dues was made by Park M. Horton, M.D., finance committee chairman.

The approved 1970 budget projects total expenses of $896,000 less reimbursement of $68,000 from the Susquehanna Valley Regional Medical Program and, to a minor degree, from the Pennsylvania Psychiatric Society. The budget for 1970 anticipates a minor surplus totaling $21,500.

Podiatry Liaison Supported

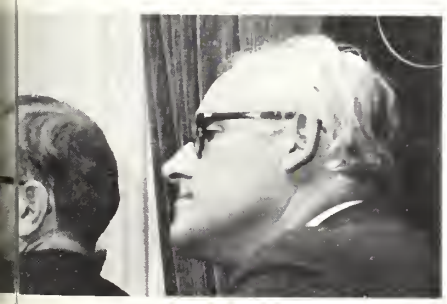
The PMS House of Delegates referred for implementation a resolution calling for formal liaison with the Pennsylvania Podiatry Association.

The resolution called for the establishment of a joint liaison committee but the approved reference committee report directed that the liaison be carried out by the existing Committee on Relationships with Allied Professions rather than form another committee.

District Model Plan Asked

The PMS House of Delegates asked that it receive at its 1970 session a model plan for the development of district medical societies as a more efficient alternative to the present county medical society structure and the assignment was given to the Committee on Objectives.

The House action came in consideration of a portion of the report of the Committee on Objectives which had started a study of the possibility of reorganizing councilor districts which led it to a consideration of a county society structure.



Seminar sponsored by the PMS Officers' Conference Committee, a highlight of the Annual Session.

The Reference Committee *on Governmental Relations discusses issues prior to action on its recommendations by the House of Delegates.*

1970 Scientific Session Directed

Citing the "surprisingly good record" of the annual PMS Scientific Session held in Lancaster in September, the PMS House of Delegates has directed that a program along similar lines be held in 1970.

The House action came after considering reports from the Advisory Committee on Scientific Session and from the parent body, the Council on Education and Science (each prepared before the Lancaster scientific session), both concluding that the annual scientific session should be dropped in favor of educational institutes.

However, the recommendations and the House action was sharply modified by the Lancaster session which recorded an attendance of members who paid registration fees at 434, or almost three times as many as a year before.

Moreover, those attendees all favored the continuance of a similar type of program in the future. The success of this recent scientific session was undoubtedly furthered by the inclusion of the specialty groups and their sharing in the support of the meetings through registration fees. The continuance of the nursing segment of the program was another favorable influence.

Fee-For-Service Action Taken

The PMS House of Delegates rejected a recommendation of the Reference Committee on Reports of Officers and instead adopted PMS Judicial Council wording of the resolution concerning payment for services supervised by a physician.

The resolution adopted by the House reads as follows: "Resolved, that the Pennsylvania Medical Society declare it to be unethical for a physician to submit or to collect a fee for medical, obstetrical or surgical service unless the physician personally provides or personally supervises the service rendered."

The sequence of events leading to the adoption of the resolution started in the 1968 House which had referred to the Judicial Council the resolution that would have declared it unethical for a physician to submit or collect fees "unless the physician is personally present when the service is rendered."

The Judicial Council said the requirement that a physician be "personally present" is unrealistic and cited as an example an instance where a data-phone transmission of electrocardiographic results to a cardiologist in another city would prohibit such a cardiologist from submitting a bill for such a service.

John B. Lovette, M.D., *Johnstown, was re-elected vice-speaker of the House.*

Remarks of Carl B. Lechner, M.D.

Recently resigned PMS President-Elect

In accepting the resignation because of ill health of Carl B. Lechner, M.D., of Erie, as president-elect, the House of Delegates with a standing ovation designated him as an honorary past-president of the Pennsylvania Medical Society and bestowed upon him "all of the customary rights and privileges extended to a past-president of this Society."

Dr. Lechner was presented with a Past-President's Medallion at the Annual State Dinner. The House also expressed its delight that Dr. Lechner would continue to serve as medical editor of PENNSYLVANIA MEDICINE.

Remarks prepared by Dr. Lechner, prior to his resignation as president-elect, distributed to the House at the suggestion of the president and considered by a reference committee which described them as "very worthwhile," are published below.

The reference committee said: "In addition to its reflections by a man who is extremely well versed in medical affairs, it gives some answers to us which we need in the area of governmental relations."

"As It Was In The Beginning"

During more than a dozen years of almost daily activity with our State Medical Society I have developed a respect for this organization which I wish to acknowledge. Since April, 1848, the Society has been accumulating experience in carrying out its purposes and in developing its structure and methods. This is, itself, a notable asset; we make up a solid, enduring structure.

In our times the Society's outstanding quality may be its adaptability. Thus, our by-laws do not put us in a rigid cast as is the case in many organizations. There is a constant revision in place of the periodic review and revision which is the common method. We have had an active committee to study commissions and committees, now no longer needed, another evidence of our refusal to be set in our ways. We can and do change. We have experimented with many new forms and relationships and continue to do so. We have not yet reached perfection but we maintain our ability to adapt.

In an age of complexity we have built a society with a corresponding variation and pluralism. It is capable of meeting present demands upon it and is designed to expand to meet the enormously greater tasks I envision in its future. Let us take a little time to draw a vignette of the Society's structure, methods and programs.

The activities of our four great councils are impressive.

The Council on Medical Service, chaired by Dr. Matthew Marshall, Jr., continues its great and innovative work in many fields. Its accomplishments in peer review are notable. This complete system of utilization and claims review mechanisms should be given full support and should by all our efforts be extended to every Councilor District and county society. Also noteworthy is the work on our malpractice crisis and on the Commonwealth's reorganization of our health and welfare services. Hospital relations has been an active field and, in my opinion, will merit more effort in the immediate future.

The Council on Public Service, headed by Dr. R. William Alexander, has been similarly active and aggressive in such fields as relations with our paramedical allies, with our future members and with groups likely to share our political

(Continued Page 35)

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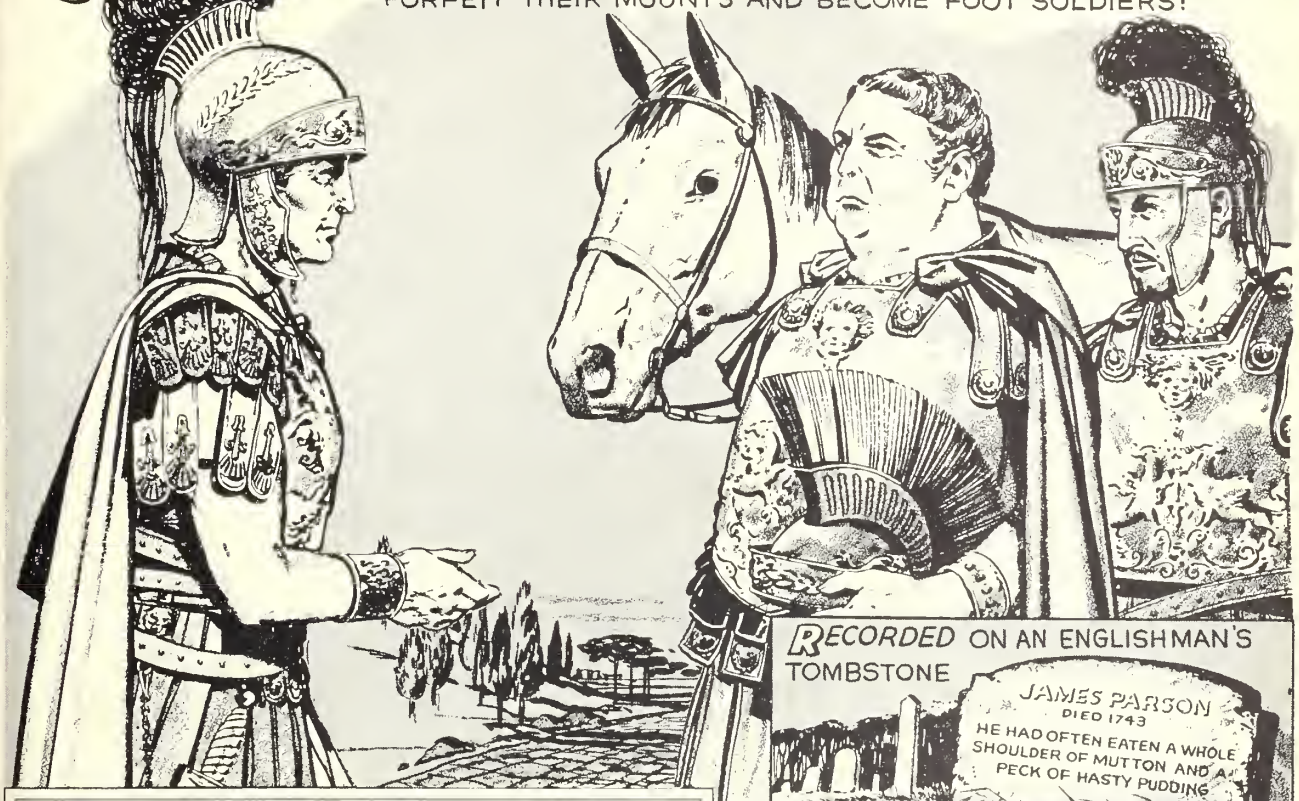

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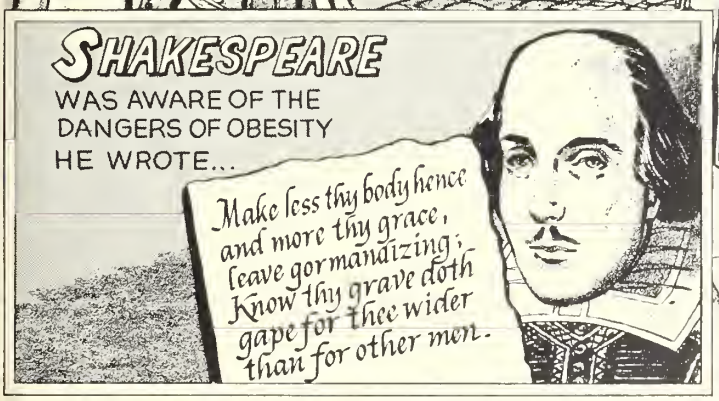
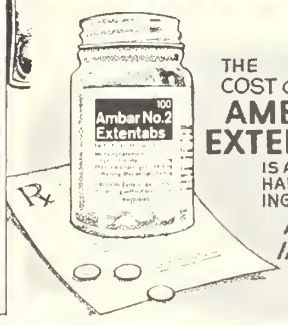
SHAKESPEARE WAS AWARE OF THE DANGERS OF OBESITY HE WROTE...





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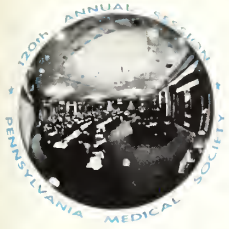

Remarks

DR. LECHNER

or socio-economic viewpoints. The number and variety of this council's activities does not allow an epitome. Let us mention the speakers' bureau, press, radio and television utilization and the counteracting of adverse publicity as spheres in which activity has been outstanding. Enlargement of our membership is an activity of this council, and the counties can profit from more activity in this field.

The greatest of boiling and bubbling is going on in The Council on Education and Science with Dr. Richard B. Magee as chairman. It has been given impossible tasks and is proceeding to perform them. Activities in continuing medical education have shown marked originality, a bold inventiveness and a considerable degree of success. In working on our out-moded convention program it has been similarly innovative. This Council is active in a great many other fields but its promulgation and coordination of continuing education is outstanding. Let us mention mental health and retardation, maternal and child health, school health and geriatrics. A wealth of new ideas and a spirit of modern medicine are at work.

The Educational and Scientific Trust has grown greatly in scope and capability. It is mentioned here because of its effectiveness in supplying funds for many of the educational programs just cited; in particular, the continuing education programs in community hospitals and the education of paramedical personnel have been well supported.

The Council on Governmental Relations with Dr. Paul Friedman as chairman has been busy with legislative problems. The introduction of bills to improve the alarming malpractice situation, the Medical Examiner Act and the Uniform Anatomical Gift Act serve as examples of our activities. Other problems such as the consent of minors to treatment and state aid for renal dialysis have been tackled. In addition, this council has supervised our annual Congressional visit and has stimulated some physician-legislator dinners. The State Board of Medical Education, the Medical Practice Act and the regulation of various paramedical disciplines have taken time, resources and energy. I omit as much as I mention; this is a busy, effective council but I foresee future activity which will put much greater demands upon it.

The Councils are the main tools of our accomplishments but could not function without the House of Delegates and the Board of Trustees and Councilors. During a dozen years of steady activity I have found the Board to be the most effective body with which I have ever been associated. The Judicial Council is another effective part of our organism. It is not necessary to list our many committees but I think we tend to underestimate the part played by our Reference Committees. The many standing and special committees give us flexibility and efficiency.

These instruments of your medical organization are integrated and often accelerated and sometimes modified by our outstanding staff, to whom we are all indebted. My own gratitude for the help and cooperation of these fine men and women is deep and abiding.

In all, the Pennsylvania Medical Society is a wonderful organization—solid and enduring yet labile and quick to act. But it is doing only a part of what it can do and only a small part of what I expect it will be called upon to do in the next few years.

Now we are in the midst of an unprecedented change in our country, a change so rapid that some call it revolution. Although not limited to health care or medicine there has been a most rapid and radical change.

Oversimplified, this consists in a plain demand *by the people* for personal health care for everyone, easily accessible, of top quality and equal for all. And, right now!

As this demand, and many similar demands unrelated to health care and doctors, filtered through the mass of the people and especially as it reached our politicians, the social scene became more and more clouded. But the basic demand remained clear.

In another oversimplification we can say that medicine was thus presented with an insoluble problem since the demand called for almost instant organizational changes in our methods of caring for people. But the demand for organization of health care services persists and comes from all segments of our civilization. It can be viewed as a vague demand for a pluralistic system involving the government as well as the private sector and supplying health care to all at a price each can afford. Private organizations interested in medical affairs (such as the Rockefeller Foundation) have gradually withdrawn and the affair is boiling down to a confrontation between government and the providers of medical care. The insurance industry is still involved and could play a major role in the coming drama of reorganization although the difficulties are great.

There is an analogy between our problems and those of the health insurance industry. We are asked to supply our services to a group of consumers who are unaccustomed to obtaining those services by our usual routes, and who often did not expect these services a generation ago.

As boiled down by the immediate past president of the AMA, Dwight L. Wilbur, M.D., there are five main problems for us to study: (1) making available high-quality health care for everyone in America, (2) health care costs, (3) realistic, mature planning of attainable realities in all of medical care, (4) unity in the health professions and (5) planning for an orderly and enhanced future.[1]

How have doctors reacted to this cataclysm of change? We have acted as individuals in our long tradition of rugged individualism. And when we do join together we sometimes act like the early Christians immediately after the departure of Christ—we close the doors and explain to each other how we are being maligned.

I propose that we move quickly to that later activity of those primitive Christians. Let us break out of our private meetings and diffuse ourselves among the people, among our fellow citizens and take a very active part in the changing political and economic life of our time. Let us have a medical diaspora.

We have always in the past been able to remain aloof and above the market place. I quote Dr. Robert Q. Marston[2]: ". . . we in the health world have enjoyed relative immunity from the political and social currents swirling around us. Health and medicine in a sense have been considered above the battle—important to society but somewhat remote from its turbulence. Statesmen have spoken kindly and rather vaguely about health, and our

own medical statesmen, with a few notable exceptions, have tended to speak with equal kindness and vagueness about society as a whole."

Dr. Marston's statement sums up our former attitude admirably.

Now we are confronted by a hodge-podge of unreasonable or ill-considered demands such as for a sudden great increase in the number of health professionals and in facilities for medical care—demands which could not possibly be met. Another phenomenon is the passage of legislation which was not sufficiently well thought out to fit into our national life and budget. That these difficulties can be worked out is seen in the way in which the heart disease, cancer and stroke legislation was modified into P.L. 89-239 with which he have been able to work. But, in the main, our world is so turbulent as to be chaotic.

Our problems must be resolved. I propose that we join more than 100 per cent in the solution. This is not merely an exhortation for each of you to get into socio-economic and political action. You are already in action. What we here must do is to return to our homes and secure the concern and involvement of every county society member. Everyone must see the problem and the urgency of it. Everyone must contribute all that he can to its solution.

Most of the problem is known to us but let us review indicators we have had in recent months to show the direction of the winds of change.

The federal government has spent more than ten million dollars yearly in medical research, education and services since 1966. There is little doubt that by 1975 the health care industry will be the first industry in the nation, employing one of every seven citizens and controlling 100 billion dollars. The size and importance of the government's role is clear.

In November, 1968, Dr. Philip R. Lee presented a paper[3] which graphically (some may say alarmingly) showed "the rapid expansion of federal activity in the areas of health and medicine" especially in the 1960's. For anyone who doubts that we will be negotiating more and more with our government, this is required reading. And greater and greater growth in these governmental activities can be predicted.

Two more straws are in the winds of change: *The American Medical News* of July 7, 1969 mentions both. One is the fact that government directives to the states specify methods by which minimum Medicaid payments are to be made. Cost control is essential to government action. The other is the Consent Decree which the College of American Pathologists entered into with the U. S. Department of Justice. This department has thus given us notice that it is prepared to litigate against any group of doctors—a legal precedent has been set. The probability of future interactions with government is enhanced.

Now is the time for me to announce the panacea. While there *is* no panacea, a remedy is at hand. The changes in our world result from the desires and demands of the people. No one can doubt that, however our government has changed, it is still a government of, by and for the people. Our solution, then, is to work with the people and this means, primarily, political activity.

I propose that our State Medical Society supervise and direct a campaign through the county societies to make sure every physician is registered to vote and that with the help of the women's auxiliary ever wife and every dependent of voting age is registered. This campaign should be extended to the Pennsylvania Association of Medical Assistants and to the students and auxiliary of the Student American Medical Association.

I propose to stir up greatly enhanced political activity at the county level, supervised and stimulated by the State Society. I advise a campaign to get every doctor, every auxiliary member, every dependent and every assistant to learn about partisan politics. I propose that we urge and assist county societies to entertain at separate times the chairmen of political parties who may be asked to explain how the doctor and his wife and assistants may begin to be active in partisan politics in the party of their choice. The auxiliary can be depended upon to spread this activity widely.

The County Societies should be informed of the availability of instructional courses in practical politics and these courses should be given and repeated to obtain as wide a coverage as possible.

We should remember that in education and political action our arm is PaMPAC. Methods of increasing its financial support are essential. More publicity could be obtained if the society were to make more space available in PENNSYLVANIA MEDICINE. The concerted action of this movement is essential to us.

We need a similar step-up in our legislative program. I propose that the State Society ask each county society to restructure its legislative committee so that each committeeman will have an assigned group of members. With the help of the auxiliary and of PAMA it might be possible to do a much better job than we have done in reaching our members when an important legislative decision is imminent. In addition we should mount a campaign to inform every member of the identity of his legislators and how to communicate with them.

We should implement the system by which each county society forms a committee of physicians and auxiliary members to act as an advisory group on medical affairs. This should be done for any legislator, state or national who resides in that county.

I also propose that we establish more "political and legislative friends." We have already been joined in such activity by the Pennsylvania Osteopathic Association. In addition we should secure cooperation from the dental society, nursing organizations at all levels, with pharmacists and with organizations of paramedical professionals.

Finally, I propose that we step up our activity in relation with the medical staffs of the hospitals of Pennsylvania. I believe that a state-wide meeting of the presiding officers of these staffs could be the beginning of a relationship which will become very productive and which will help us in our effort to keep the physician preeminent in patient care.

The Pennsylvania Medical Society will, by virtue of its experience, structure and capabilities, be the normal agent to carry out the discussions with government and other concerned groups which appear to be on the horizon. Let us strengthen and extend its capabilities to make it more effective. We can only keep our preeminence by meeting the needs of the people. CBL

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Milking Machines and Medical Management

JOHN F. RINEMAN

appointed new Executive Director by the PMS Board of Trustees

A Milton Hershey School farm boy who once tried out for the Brooklyn Dodgers as a first baseman and then studied to be a sportscaster last month became the manager of the "team" of 12,000 medical doctors in the state.

In a step far removed from his goals and interests of earlier years, John F. Rineman of Hershey was promoted to the executive directorship of the Pennsylvania Medical Society by the Board of Trustees and Councilors.

His promotion came when Lester H. Perry of Lemoyne retired as executive director after thirty-five years of service.

Mr. Rineman at the age of 42 thus becomes one of the youngest medical society directors in the nation. He joined the medical society staff fourteen years ago and immediately prior to his appointment was the assistant executive director.

Mr. Rineman and his wife, the former Ruby Huffman of near Hershey, live at 1011 West Areba Avenue in Hershey with their three children: Valerie, 10; Timothy, 7; and Mark, 5.

His father and stepmother, Mr. and Mrs. John E. Rineman, live at 1671 Oregon Pike, Lancaster, and a sister, Mrs. George A. Rodgers, resides in Paradise, Lancaster County.

Mr. Rineman was eight years old and attending elementary school in Manheim Township near Lancaster when the death of his mother started the unlikely sequence of events that led him to the administrative head of the third largest state medical society in the country. With the death of his mother, John's father found it extremely difficult to work and give proper parental supervision to two young children and it was arranged for John to go to the Maple Lawn unit of the Milton Hershey School where admission is restricted to children with one or both parents deceased.

Growing up in an "adopted family" of about twenty other children undoubtedly develops a competitive spirit. At least, such a trait shows up in John whose share of work on the farm covered everything from hoeing corn to milking cows.

John excelled in the baseball games that all youths play and by the time he got to high school, he chose the academic course because he wanted to go to college to study to be a sports announcer. He played first base well enough to earn a tryout with the former Brooklyn Dodgers in the fall of 1944. Although he didn't win a berth on a farm team (he struck out in three times at bat) his interest in sports continued throughout his fifteen-month tour of Navy duty that ended in the summer of 1946. World War II ended while he was in Navy "boot" camp at Sampson Naval Training Station. Following boot camp, he served aboard the battleship *North Carolina* in the Atlantic until he was discharged.

Following his discharge, he returned to his Milton Hershey unit as base while he attended Hershey Junior College for two years and then enrolled as a junior at Boston University where he earned a B.S. degree in radio and television, with a minor in public relations in the spring of 1950.

He then went to work as a sports announcer for radio station WLAN in Lancaster where he covered a variety of sports activities—including the Jersey Joe Wolcott-Rocky Marciano title bout in 1951. After three years of the "glamour" of radio, John met the girl who was to become his wife and found that the prestige of sportscasting wouldn't buy groceries. He left the station to become an insurance salesman and got married in August of 1954 despite the fact that —in his words—he was a lousy salesman and wasn't earning much money.

In 1955, he answered a "blind" newspaper advertisement seeking a man with radio and television experience. The prospective employer was the Pennsylvania Medical Society, then headquartered in Harrisburg, and he ultimately was hired as a public relations assistant responsible for radio and television activities. He became public relations director of the Pennsylvania Medical Society about two years later and following a second promotion, became assistant executive director nine years ago.

The Rinemans lived for fifteen years in Hummelstown where he was active in the Zion Lutheran Church and in borough and school district politics. He is a former member of the church council and still teaches a Sunday school class on occasion.

His interest in sports and in the Milton Hershey School resulted in his being the public address announcer at Milton Hershey home football games for fifteen years until this fall when he stopped because of his other responsibilities. He moved to Hershey earlier this year.

When Mr. Rineman joined the Pennsylvania Medical Society staff in 1955, it employed twenty-three persons and since has almost trebled in size. As its executive director, he supervises the staff implementation of the scores of scientific, health education and socio-economic activities in which the professional association of medical doctors in the state is involved.

He is a member of the board of directors of the American Association of Medical Society Executives; a member and currently vice-president of the Harrisburg Chapter of the Public Relations Society of America; a former president of the Pennsylvania Public Relations Society; a former chairman of the Advisory Committee to the Communications Division of the American Medical Association; and a past president of the Hershey Optimist Club.

Recently, the milking machine broke down on the farm of John's father-in-law and on that morning John called on his skill learned at the Milton Hershey School. The now executive director of the Pennsylvania Medical Society milked eleven cows before he hurried home to change clothes and then go to tug at the problems that beset any professional association.

Dane S. Wert

Officers of the Women's Auxiliary *of the Pennsylvania Medical Society for 1969-70 are shown above. Elected at the forty-fifth convention of the auxiliary, they were presented to the convention in session by Mrs. Jacob Ripp, nominating committee chairman. Left to right are: Mrs. John A. Schneider, president; Mrs. Leroy A. Gehris, president-elect; Mrs. Frederick R. Gilmore, first vice-president; Mrs. John H. Eves, eastern regional vice-president; Mrs. Stephen D. Lockey, central regional vice-president; Mrs. Morgan F. Taylor, western regional vice-*

Almost 200 delegates, alternates and members of the Women's Auxiliary of the Pennsylvania Medical Society gathered at the Marriott Motor Hotel, Philadelphia, October 9-12 for their forty-fifth annual convention. They were welcomed to the City of Brotherly Love by Mrs. J. Antrim Crellin, president of the Philadelphia County Medical Society Women's Auxiliary, and a response to her remarks was delivered on behalf of the delegates by Mrs. James E. McMillan, president of the Allegheny County auxiliary. Convention chairmen Mrs. Richard T. Smith and Mrs. J. Stauffer Lehman were presented at the opening session.

Awards were presented to the county societies which contributed the most on a per capita basis to various

45th Annual Convention

PMS Women's

Mrs. John M. Chenault, *left, delivers a major address at the second session of the forty-fifth convention of the Women's Auxiliary of the Pennsylvania Medical Society. Below, members of the Gavel Club, composed of past presidents and honorary members, gather prior to their dinner, an annual convention event.*

president; Mrs. Ralph S. Blasiole, treasurer; Mrs. Alfred T. Johnson, recording secretary; Mrs. C. Henry Bloom, financial secretary; Mrs. Ripp; Mrs. Frank J. Corbett, speaker of the house of delegates; Mrs. Charles A. Waltman, councilor-elect, Third District; Mrs. Robert L. Harding, councilor-elect, Fifth District; Mrs. Spencer J. Servoss, councilor-elect, Seventh District; Mrs. Thomas E. Patrick, councilor, Fourth District; Mrs. William R. A. Boben, councilor, Twelfth District.

funds. Clinton County took the honors for support to the AMA Education and Research Fund. The Mifflin-Juniata group gave the greatest amount per capita to the Educational Fund, and the Greene County auxiliary to the Medical Benevolence Fund.

In action taken by the PMS House of Delegates the Women's Auxiliary to the Pennsylvania Medical Society was commended for its work with health careers, community health projects and public health education.

Both Mrs. Axel K. Olsen, past president, and Mrs. John A. Schneider, president, spoke of the auxiliary's theme "Accent on You—Dear World," referring to the efforts members can make to improve their world. Regional workshops to implement the theme are scheduled in the weeks ahead.

Auxiliary

In the picture to the right, Mrs. John A. Schneider, *left, incoming president, receives the gavel from Mrs. Axel K. Olsen, immediate past president of the PMS Women's Auxiliary. Below, delegates to the Women's Auxiliary 45th annual convention hear Mr. Donald Barnhouse, news analyst for WCAU-TV, Philadelphia, speak following the Presidents' Luncheon.*

THE RESPONSE GAP

Symptom reduction often begins within the first week with AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

All antidepressants take time to work. With Aventyl HCl, patients who will respond often begin to receive symptomatic relief within the first week of therapy. They may report sounder sleep, better appetite, increased interest, or other noticeable improvement in mood or activity.

In a study of two tricyclic drugs, "nortriptyline was associated with a more rapid symptom reduction during the first three weeks of treatment."* However, the author also reported that although some differences in response existed after three weeks, "they were no longer significant by the sixth week of treatment."* *Of course, maximum improvement with Aventyl HCl, as with other antidepressants, may require longer therapy, particularly in severe depressive illnesses.*

Aventyl HCl may help shorten the response gap . . . provides measurable symptomatic relief your patients often notice and appreciate.

*Mendels, J.: Comparative Trial of Nortriptyline and Amitriptyline in 100 Depressed Patients, Amer. J. Psychiat., *124*:59 (Feb. Supp.), 1968.

10 mg.† 25 mg.† 10 mg.† per 5 cc.

†base equivalent

AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

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AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

Psychophysiological gastro-intestinal disorders and symptomatic reactions in childhood (e.g., enuresis).

Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two weeks after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl HCl under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Patients receiving a tricyclic antidepressant (e.g., nortriptyline) may respond poorly to hypotensive agents such as guanethidine.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily
10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily
10 mg.—Ages three to six, 1 Pulvule one to three times daily
Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily
Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500. [081668A]

Additional information available upon request.

Eli Lilly and Company
Indianapolis, Indiana 46206

900816

PENNSYLVANIA MEDICINE

newsfronts

Chicago Management Consultant Claims

Hospital Inefficiency Largely Mythical

The American hospital system, despite recent criticism, may actually be more efficient and less costly than any other that can be devised, according to a management consultant who specializes in the hospital field.

Speaking to the Health Insurance Council's 1969 Leadership Conference at St. Charles, Ill., Richard L. Johnson, vice president of A. T. Kearney and Co., Chicago management consultants, said that the "inefficiency" surrounding the hospital system is largely mythical.

"There are so many in contact with hospitals who are awfully sure of things that are not so," Mr. Johnson said. "They have firmly made up their minds that hospitals are inefficient and are perfectly willing to change the known system for an unknown system on the basis of this belief.

"It may just turn out," he added, "that the present hospital system, with all of its problems, is more efficient and less costly than any other that can be devised."

Like "all other" American industries, hospitals can be made more efficient than at present, he said. But he added that opportunities for cost reductions are "not nearly as great as one might believe when listening to stories about hospital inefficiencies."

It is rare, Mr. Johnson said, to discover a hospital where reductions in excess of 15 per cent can be made in operating costs.

He cited a "total systems study" his firm had conducted on an existing hospital that was to be rebuilt on a new site.

"We put together a team composed of industrial engineers, systems specialists, data processing specialists, statisticians, and hospital administrators. The team applied all of the latest tools and techniques of the management sciences and coupled them with engineering performance standards.

"The results of all of this effort was that the anticipated cost of construction was reduced by 15 per cent."

However, he said, the client reinvested much of the savings in equipment to improve patient care, such as a coronary care unit. This reinvestment, he said, cut the 15 per cent construction savings to 5 per cent. A reinvestment in services and programs on the operating side of the picture cut a 10 per cent savings to 2 per cent.

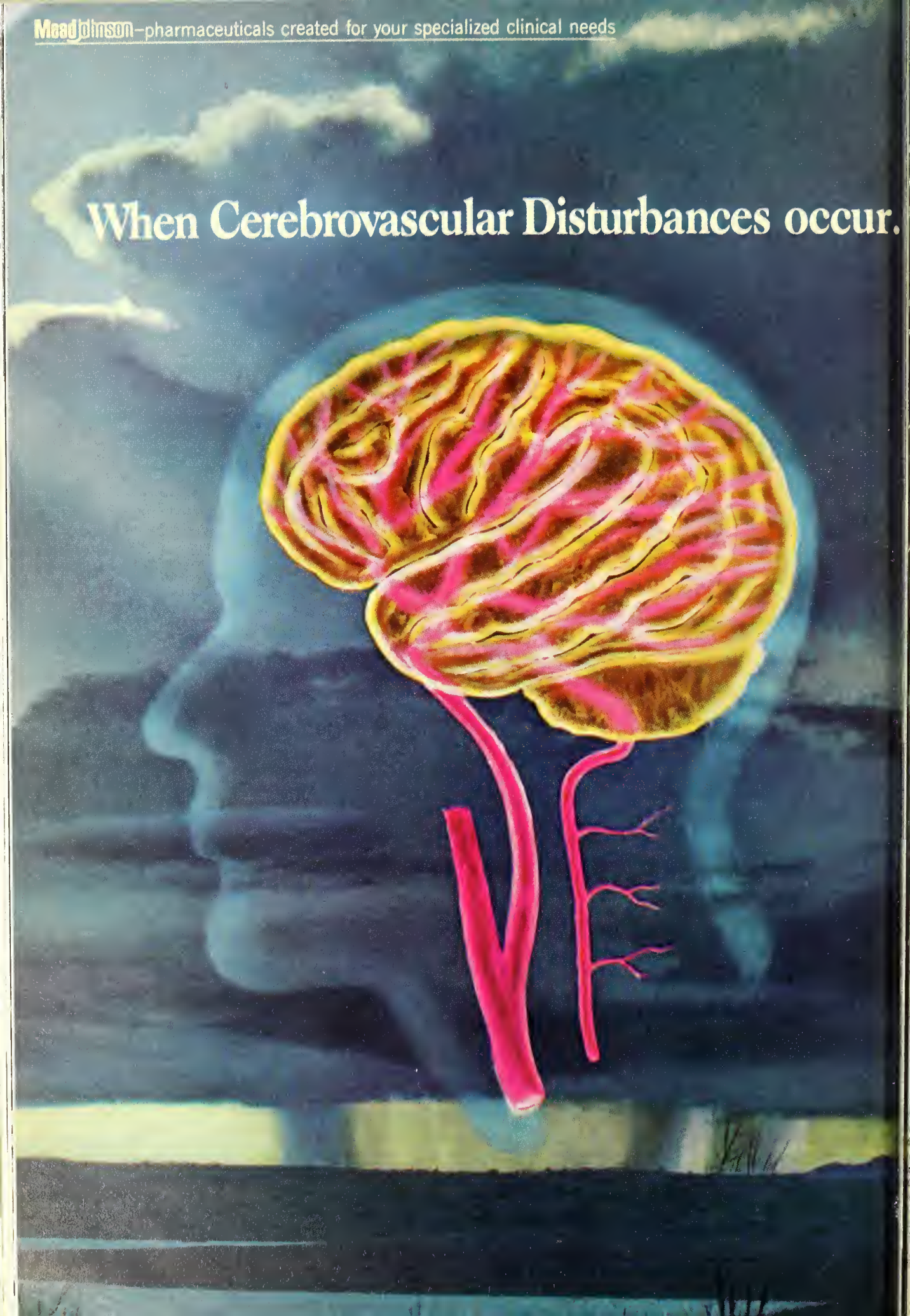
(Cont'd. on Page 53.)

Dr. Daugherty Honored

In memory *of the late J. A. Daugherty, M.D., chairman of the board of directors, Pennsylvania Blue Shield and honorary member of the Pennsylvania Association of Medical Assistants, Mrs. Virginia K. Daugherty, chairman of the medical assistant's memorial committee, presents in behalf of her organization a lectern honoring Dr. Daugherty to be used in the Blue Shield board of directors room. The lectern is received by Matthew K. Gale, president of Pennsylvania Blue Shield. Dr. Daugherty was Blue Shield board chairman at the time of his death last August and previously served as that organization's president for twenty-one years.*

Mead Johnson—pharmaceuticals created for your specialized clinical needs

When Cerebrovascular Disturbances occur.



...with episodes of vertigo, headache, confusion, sensory loss, slurred speech, consider

VASODILAN®
(ISOXSUPRINE HCl)

to help relieve symptoms by preventing vasospasm and increasing cerebral blood flow

Mead Johnson
LABORATORIES

Although not all clinicians agree on the value of vasodilators in vascular disease,[1] several investigators[2-5] have reported favorably on the effects of isoxsuprine on cerebral blood flow. Effects have been demonstrated both by objective measurement[2-5] and observation of clinical improvement.[2-4]

Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODILAN tablets, isoxsuprine hydrochloride 10 mg. **Dosage:** Oral—10 to 20 mg. (1 or 2 tablets) t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Fazekas, J. F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. F., and Savarese, C. J.: Angiology *15*:No. 2 (Feb.) 1964. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, T. B., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: Current Therapeutic Research *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964

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Medals to Honor Medical Milestones

Pa. Firm Mints Healing Art Saga For Subscribers

A series of sixty proof-quality art medals depicting major medical advances over the past 4,000 years will be issued on a limited-edition, subscription-only basis beginning in October, 1969, by the Medical Heritage Society of Chicago. Struck in bronze, sterling silver and solid platinum, the bas relief art medals will adapt historical art to illustrate significant milestones of medical progress.

A distinguished panel of medical historians, headed by Dr. Lester King, has been created to select the individuals and subjects to be included in the series. Dr. King is the senior editor of the *Journal of the American Medical Association,* and a professorial lecturer in medical history at the University of Chicago. Others on the advisory board are: Dr. L. R. C. Agnew, associate professor of medical history at the University of California; William K. Beatty, librarian and professor of medical bibliography at the Northwestern Medical School; Dr. Charles W. Bodemer, professor and chairman of the University of Washington Medical School's department of biomedical history; Miss Ronnie Beth Bush, assistant professor and vice-chairman of the Chicago Medical School's department of history and philosophy of medicine; Dr. John Duffy, Tulane University professor of medical history; Dr. Genevieve Miller, director of the Howard Dittrick Museum of Historical Medicine and an associate professor of the history of science at Case Western Reserve University School of Medicine; and Dr. Peter D. Olch, deputy chief of the National Library of Medicine's History of Medicine Division.

Artist Jill Lamb, *of Ridley Park, Pa., uses sketches of a Jenner statue to design a model coin-type medallion for the Medical Heritage Society's history of medicine series. She is one of the few such talented people in the world to have this skill. A total of sixty art medals will be offered in The Medallic History of Medicine series.*

The art medals are offered on a subscription basis only at a cost of $1,180 per medal in platinum, $12.50 in silver, and $4.50 in solid bronze.

Each medal will be accompanied by a historical reference folder describing its significance in medical history. Each is 39 mm. in diameter, larger and thicker than a silver dollar. Medals struck in silver and platinum will carry subscription numbers, and all medals will be hallmarked.

The medals will be minted at the Franklin Mint, Yeadon, Pa., and will be distributed on a two-a-month basis

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.

The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.

A realistic approach to pain relief

'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

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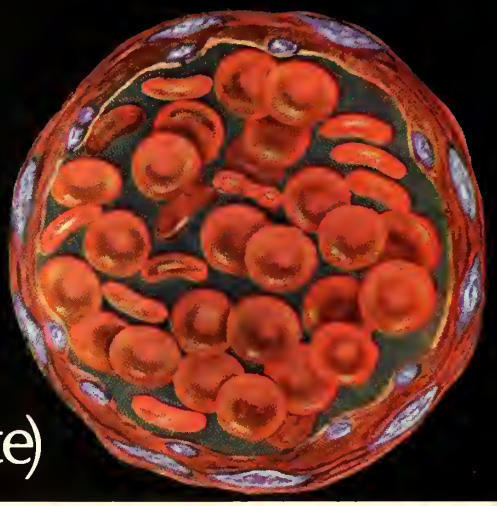
Tuckahoe, N.Y.

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



Because peripheral vasodilation is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

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Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided b sustained-release Roniacol Timespan (nicot alcohol tartrate) Tablets. Part of the drug be comes available immediately, the remainde continuously over a period of up to 12 hour and dilation of constricted peripheral vesse usually maintained. Thus, with a single dose medication, patients can enjoy the benefits increased peripheral blood flow in ischemi extremities for up to 12 hours.

Smooth peripheral vasodilation from initial dosage...extended with simple, well-tolerated, b.i.d. dosage

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efo e prescribing, please consult complete ro uct information, a summary of which llows:

dications: Conditions associated with efi ent circulation; e.g., peripheral vascular se se, vascular spasm, varicose ulcers, ecubital ulcers, chilblains, Meniere's syn- ore and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

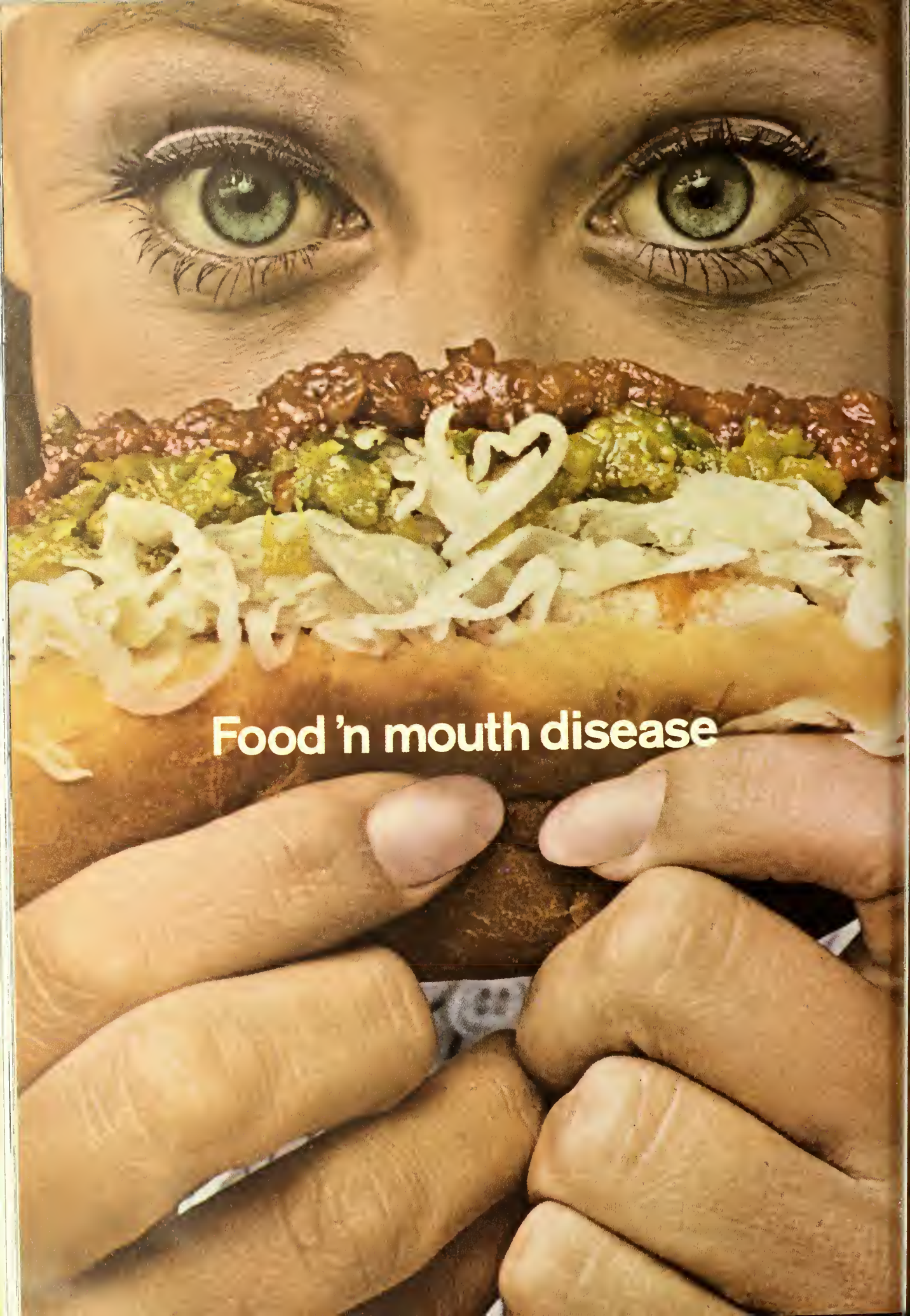
Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE

Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.


Food 'n mouth disease

Preludin® phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
(B)R3-46-560-B

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For complete details, please see full prescribing information.

Geigy Pharmaceuticals
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Ardsley, New York 10502

For some, obesity can be a serious complication of moderate hypertension, diabetes, or pregnancy.

Preludin may be used to curb appetite in obesity associated with such conditions.

For use during pregnancy, please consult Warning paragraph. The use of Preludin in moderate hypertension should be accompanied by caution. In diabetes, the drug does not increase insulin requirements (requirements may be reduced as weight is lost).

One 75-mg. Endurets tablet taken between breakfast and midmorning will usually provide daylong and early-evening suppression of appetite.

Preludin® phenmetrazine hydrochloride Endurets® prolonged–action tablets

PF 611

newsfronts

Temple Group Seeks Health Career Recruits

Temple University Health Sciences Center has formed a committee, which includes representatives of its four professional schools and the community, to find and assist more disadvantaged young persons in preparing for a career in the health field.

The committee was established by L. E. Burney, M.D., Temple University vice president for health sciences, and is headed by James A. Batts, M.D., chief of obstetrics at the university's hospital.

"We will not limit our efforts to any particular group, but will help anyone we feel is disadvantaged and may encounter some obstacles in trying to raise his horizons and seek a higher level of education," Dr. Batts said. "In our particular location, however, 'disadvantaged' means black and Puerto Rican.

"Our specific duties are to find where potential applicants are, to point the applicants in the right direction, to give them motivation and let them know someone is really interested in them, and to follow them through and see to it that there are no unreasonable barriers placed before them."

In addition to representatives from the North Philadelphia community around the health sciences center, other committee members include representatives from Temple's schools of medicine, dentistry, pharmacy and allied health professions and student body as well as members of Temple programs which assist young people in furthering their education, PRODIGY and Temple Opportunities Program.

Dr. Batts emphasized that his committee is not seeking students who are not capable to enter medicine, dentistry or other health careers.

"To take such a student and put him in an environment he can't adjust to would worsen the situation," he said. "You would frustrate the boy more than help him.

"I'm talking about the borderline or average student, because to me you don't have to be a brain to be a good doctor, you just have to like people and have the ability to study certain required subjects. I know one bright student, a Phi Beta Kappa, who will never make it as a doctor; he probably will go into basic research."

The committee has three goals. The immediate one is to increase the number of disadvantaged students in next year's freshman enrollment at Temple's professional health career schools. An intermediate phase is to help juniors and sophomores in college take required courses to prepare for the medical aptitude test. The third goal is to counsel and motivate high school students so they will meet the requirements when they apply.

He urged disadvantaged students applying to the schools to identify themselves to the committee and take advantage of the help it can supply.

120-year Tradition Broken As Men Enroll At Women's

The board of corporators of Woman's Medical College has voted to admit men to this heretofore all female medical college. In making this announcement, Mrs. Paul R. Kaiser, chairman of the board, stated that this major decision, probably the most important made in the history of this internationally famous 120-year-old institution, was the result of several years of thorough research against a background of changing times and changing world conditions.

"When the college was founded in 1850," said Mrs. Kaiser, "it filled a great need. Women were barred from attending medical schools, and only with the founding of Woman's Medical College were women for the first time able to engage in the pursuit of medical education unfettered by traditional taboos."

"Today," said Mrs. Kaiser, "this condition no longer exists. Women are now admitted to the nation's medical schools and our college must, as always, be dedicated to the continuance of women in medicine, and to excellence in medical education regardless of the candidate's sex."

Amplifying the decision, Mrs. Kaiser further noted that the report of the board's admission policies committee, chaired by Mrs. John T. Brugger, strongly recommended co-education at Woman's Medical College from many viewpoints, not the least of which is the continuing ability to attract high caliber faculty, interns, and residents in a highly competitive professional arena. Another benefit of co-education will be the increased ability to attract public, private and industrial financial support.

With regard to WMC's continued commitment to women in medicine, Mrs. Kaiser sounded a reassuring note in pointing out that the board in its decision to become co-educational specified that, except for a short transitional period, additional admissions for men would be supplementary to future enrollments of the college. The new admissions policy will be effective immediately and action will be taken on such men students as have already applied for admission.

First Tests Set For Family Practice

The American Board of Family Practice has announced that it will give the first examinations for certification in various centers throughout the United States over a two-day period, February 28-March 1, 1970. Information regarding the examination and eligibility for the examination can be obtained by writing to: Nicholas J. Pisacano, M.D., Secretary, American Board of Family Practice, Inc. University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

Geriatric Complex Accepted For Warren State

The State Department of Public Welfare has announced acceptance from the General State Authority of a 700-bed "Institute for Geriatric Research" building complex constructed by the GSA at Warren State Hospital in Warren County.

Joseph Adlestein, M.D., deputy secretary for mental health and mental retardation, said the complex, built at a construction cost of $8,443,305, "provides the Warren institution with modern facilities for the care of elderly mental patients and utilizes modern structural know-how through special design for the institutional care of the aged."

The complex was accepted with an agreement that corrections would be made by GSA contractors to a number of minor structural items in the facility.

Bed-care patients requiring extensive service will be housed in a compact six-story wing. A laboratory which deals predominately with geriatric research, will be located on the top floor. This unit will house 320 patients.

The ambulatory patient section of the complex, housing 380 patients, is made up of six single-story nursing wings, each with two day rooms, bedrooms, lavatory and laundry facilities, storage space, nurses' stations and mechanical equipment rooms.

AMA Clinical Convention Set

The American Medical Association will hold its 23rd Clinical Convention in Denver, Nov. 30 through Dec. 3.

This year's AMA Clinical Convention is the third to be held there. Denver previously was host city in 1952 and 1961.

Scientific sessions are planned for mornings and afternoons, Monday through Wednesday, covering the latest developments in a variety of areas including heart disease, cancer, and pulmonary problems.

Hospital Linkup To Be Studied

The regional medical programs *are proving that automated electrocardiography is feasible in any hospital, not just those in large cities. Successful projects throughout the nation are linking small community hospitals with larger institutions to provide rapid and accurate analysis of a patient's EKG tracings. Such a project has been under development for over a year within the Susquehanna Valley Regional Medical Program. It was reviewed for its scientific merit on September 17 by the Council on Heart Disease and was approved. The Regional Advisory Group of SVRMP will study the project November 6. If this group approves, request for funding the project will be submitted to the Federal Division of Regional Medical Programs. Approval and funding will mean that twelve hospitals can receive same-day computerized analysis of EKG tracings from a computer center which will be located in the Harrisburg area. In the above picture, testing the type of equipment used in such a project, are, left to right, Martin W. Ferrante, SVRMP systems analyst, George T. Raber, director of physiology, and Donna Williams, EKG technician.*

Hospital Inefficiency (Cont'd. from Page 43)

"From previous experience," he said, "this was about what we had anticipated. This represents the world of reality, not the myths currently surrounding the hospital system."

Mr. Johnson said that "far and away the most important" improvements would be to create "incentive" in hospitals. The cost reimbursement formula used by Medicare and Blue Cross to pay hospitals for their services "works against" improving efficiency, he said.

"Under such a system," he noted, "there is little or no incentive to make improvements in labor efficiency, since the result is a lower reimbursement from the prepayment agency."

newsfronts

Chronic Diseases Director Appointed By State

Catherine B. Hess, M.D., a clinical research scientist in the fight against cancer, has been appointed director of the division of chronic diseases for the Pennsylvania Department of Health.

The appointment, effective October 1, was announced by Thomas W. Georges, Jr., M.D., Acting Secretary of Health. For the past four years, Dr. Hess has served as assistant chief for clinical programming of the federal cancer control program in Washington.

In her new post, Dr. Hess will carry out existing programs and develop new approaches in preventing and controlling chronic diseases including heart, cancer, stroke, diabetes, arthritis, and others. Her annual salary will be $23,915.

Dr. Hess, a certified obstetrician and gynecologist, has been in the front line in the fight to control cancer for the past four years. She supervised thirteen mammography training centers throughout the United States which trained medical personnel in the early detection of breast cancer. She developed demonstration screening programs and supervised research in new diagnostic devices, such as ultrasonics, xerography, liquid crystals and thermography.

Dr. Hess collaborated in the development of a new surgical technique in cervical cancer called "cryosurgery" which entails freezing the cervix during surgery to prevent the spreading of cancerous cells.

A native Pennsylvanian, Dr. Hess lives in Boiling Springs, near Carlisle.

Before going to Washington, Dr. Hess was assistant commissioner and executive director of chronic diseases of New York City. She also served as chief of the addictive diseases section of New York City.

During her service there, Dr. Hess established and supervised mass screening programs in diabetes, glaucoma, and cancer detection. She also directed the city's programs for addictive diseases, smoking, alcoholism, narcotic and drug abuse. She was instrumental in establishing anti-smoking clinics and promoted programs in schools to persuade teenagers not to develop the habit of smoking.

Catherine B. Hess, M.D.

In the field of addictive diseases, Dr. Hess set up a narcotics registry which eventually registered 50,000 addicts. More than 11,000 of these were given detoxification treatment. A day-care center was opened to assist former addicts in total rehabilitation.

Dr. Hess also headed the New York City nutrition program which conducted studies in nutrition as a possible cause of coronary artery disease.

Prior to her service in New York City, Dr. Hess was medical director of the Philadelphia Division of the American Cancer Society for ten years, where she directed the city-wide cervical cancer programs. She was also chief of adult health services in the Philadelphia Department of Health.

A fellow of the American College of Surgeons, Dr. Hess was in private medical practice for twelve years in Philadelphia. She received her medical degree from Temple University School of Medicine in 1941, and received her master's degree in public health in 1959 at Columbia University, New York City.

Hershey Medical Founders Feted At Convention

Two of the men who helped bring The Milton S. Hershey Medical Center of The Pennsylvania State University into existence received recognition at the Orientation Week Fall Convocation.

Portraits of Samuel F. Hinkle and George T. Harrell, M.D., will be presented by Dr. Eric A. Walker, president of the university, for placement in the Medical Sciences Building lobby. The oil paintings are by Erik Haupt of New York City.

Hinkle, retired president and chairman of the Hershey Foods Corporation, was a key figure in the establishment of Pennsylvania's first new medical school in sixty years. As a member of Penn State's Board of Trustees and the Boards of Managers of both The M. S. Hershey Foundation and the Milton Hershey School, he was instrumental in bringing the agencies together for the project with the now legendary "$50 million phone call" to Dr. Walker in 1963.

Dr. Harrell was appointed dean of the College of Medicine and director of the medical center in 1964. He formulated the innovative philosophy and physical plant that has brought the school international attention and a deluge of applicants. He continues to direct the development and daily operation of the center which has begun its third year of classes.

in the treatment of

IMPOTENCE

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(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"*Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study"* – *Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 *strengths*

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Each yellow tablet contains

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily

Available: Bottles of 100, 500, 1000.

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Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

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EXTRA HIGH POTENCY

Each orange tablet contains

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Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.

Available: Bottles of 60, 500.

REFER TO PDR

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WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
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Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily

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Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

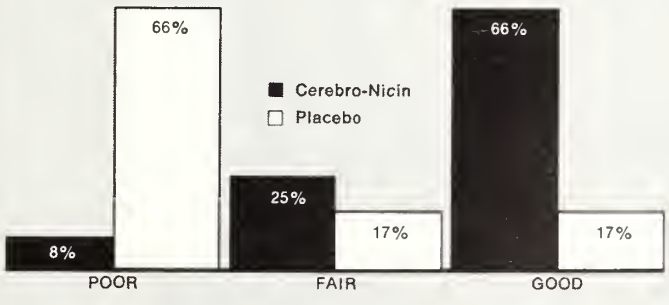
INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin® capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.

AVAILABLE: Bottles of 100, 500, 1000 capsules.

Also elixir pint bottles.

CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.

Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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Drug Foundation Faces Urban Crisis

Projects dealing with the rapidly developing urban crisis were given a high priority in 1968 by the Smith Kline & French Foundation which contributed $908,970 for charitable, educational and scientific purposes.

The foundation is a charitable trust established in 1952 by Smith Kline & French Laboratories, Philadelphia manufacturer of prescription medicines and other health-related products. Its total contributions have been $11,010,766.

Last year approximately one-half of the foundation's contributions were for educational purposes. Altogether, grants designated for public charity and community improvement projects, and for education constituted 90 per cent of the foundation's total contributions. The remaining grants were made to promote mental health, to match employe gifts and for a few miscellaneous purposes.

Funds for public charity and community improvement totaled $346,806. The largest grant, $137,820, was made to Philadelphia's United Fund.

A pledge of $44,000 went to the Greater Philadelphia Foundation for a Black Coalition minority youth program, a project that grew out of a meeting between leaders of both the white and black communities. Philadelphia business pledged $1 million to support Coalition projects, and $30,800 was paid during the year toward the foundation's pledge. The money was used to help the hard-core unemployed and to improve housing, education and health services in the inner-city.

Other groups working on inner-city problems also received grants, including the Urban Coalition which was given the largest sum, $25,000.

Grants amounting to $78,866 were made to eight hospitals in the Philadelphia area for building, expansion or improvement programs. This total includes a $25,000 payment on a $100,000 pledge to the new Children's Hospital-Philadelphia Child Guidance Clinic-Oakbourne Hospital complex.

The foundation gave more than $345,000 to support educational projects and programs in medicine and biomedical sciences.

Sixteen unrestricted grants totaling $88,500 were made to newly appointed educators in medicine, pharmacy and mental health. These grants ranged from $1,000 to $10,000 and generally were used to implement projects for which funds were not otherwise available.

Contributions for mental health programs totaled $54,100. The largest amount, $15,000, went to Horizon House's new psychiatric rehabilitation center in Philadelphia. This latest grant brings the foundation's total gifts to Horizon House to $75,750.

Miscellaneous grants totaling $64,844 included an unrestricted grant of $10,000 to the recently created Leonard Davis Institute of Health Economics of the University of Pennsylvania. The institute studies the economic and social aspects of health care and health care coverage.

In matching employe gifts to educational institutions and hospitals, the Foundation contributed $95,160 to 173 institutions of higher learning, 70 secondary schools and 36 hospitals.

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FDA Awards Contract

Temple To Study Effects of "Pill"

The Institute for Survey Research of Temple University has been awarded a contract by the Food and Drug Administration for a study dealing with the relationship between oral contraceptive pills and abnormal cervical cytology.

The contract is for an eight-month developmental phase of a prospective five-year study. Dr. Aaron J. Spector, director of ISR, and his project co-directors, Howard Balin, M.D., and Irwin Breslow, M.D., have established liaison with approximately thirty Family Planning Clinics in all parts of the country, representing white, Negro, Latin-American and Indian women of all economic classes.

Approximately 30,000 women who are either taking marketed oral contraceptive pills, or are wearing an intra-uterine-device or using a diaphragm will be checked for a five-year period. Upon entrance into the study, each woman will have a Pap smear and a physical examination, with Pap smears repeated during the five years.

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M.D. Retraining Program Accelerated

If you are an inactive physician, our country needs you to keep it healthy. Would you like to return to practice, but feel you need to brush up on your skills? Whether you are a man or woman physician, Woman's Medical College of Pennsylvania can give you that chance to participate in a retraining program designed to meet your individual needs. The opinion was expressed by Ethel Weinberg, M.D., WMC assistant dean and director of the college's—and the country's—only program to retrain inactive doctors.

Last October, assisted by a Josiah Macy, Jr., Foundation grant, the college initiated a nine-month training course for inactive women physicians, who have, since completing the course, resumed medical practices or gone into residencies.

This fall, aided by an initial $120,286 grant from the Greater Delaware Valley Regional Medical Program, the college will offer even more flexible retraining programs to include both men and women physicians.

Who would make likely retrainees? It could be a woman M.D., who became medically inactive while her children were pre-school age; or, it could be a woman specialist, who, now that her children are grown, would like to resume practice, but feels she is too rusty. Or, it could be a male physician, who would like to return to clinical medicine.

What types of programs could WMC offer? Dr. Weinberg pointed out, "Since potential retrainees may have different needs, the college will make every effort to tailor the programs to help them the most."

"One possible program might be," she said, "a full time, six-week course which would offer a review of diagnosis skills combined with a lecture series covering latest developments in general medicine, pathophysiology, diagnosis and treatment. Afterwards, a clinical program might be set up in the physician's home town hospital, where he or she could have a preceptorial or residency-type experience which WMC would attempt to arrange."

Dr. Weinberg indicated, "Another course might prepare physicians for specializing in family planning or intensive care. Still other courses could be arranged, depending upon the number of persons interested, but to do this effectively, we must know about the interests, requirements and resources of physicians, who might participate."

"Responses to a questionnaire sent to many inactive physicians, indicates," she said, "both men and women are interested in updating their medical education."

For more information about the pioneer program, that could help return you to active practice, contact Dr. Ethel Weinberg, Assistant Dean, Woman's Medical College of Pennsylvania, 3300 Henry Ave., Philadelphia, Pa. 19129 (Area Code 215—VI 9-0400, Ext. 308.)

Target: High Cost of Care

Grants Awarded For Medical Career Recruits

Grants totaling $65,000 to recruit young people into vitally needed medical careers were announced recently by George E. Farrar, Jr., M.D., president of United Health Services (Philadelphia) and past-president of the Pennsylvania Medical Society.

A breakdown of the grants revealed that $14,000 went to the schools of nursing at Philadelphia General Hospital, Albert Einstein Medical Center and Pennsylvania Hospital to upgrade students to qualify for entrance requirements into nursing.

An additional $6,000 went to Simon Gratz High School to help defray the cost of preparing a group of selected youngsters from a deprived ghetto area to enter the field of medical research as assistants.

Existing health career programs of United Health Services were funded in the amount of $45,000 to Jefferson Medical College Hospital for another year. These include a demonstration project to prove the effectiveness of a health careers guidance clinic and a program to recruit and train health information workers who will inform and educate persons living in deprived areas of existing health facilities available to them.

The health careers involved include medical and laboratory technicians, x-ray technicians, medical researchers, medical secretaries, inhalation therapists, physical therapists, medical librarians, practical nurses, registered nurses, and numerous other medical specialties.

In announcing the medical career grants, Dr. Farrar pointed out that one of the reasons for the high costs of medical and hospital care is the lack of trained personnel in para-medical fields such as nursing, laboratory technology and others.

"These grants," declared Dr. Farrar, "will help motivate young people into entering vital medical careers. In addition many young people who need help in getting jobs, especially those from deprived areas, will be given a head start toward entering medical careers."

United Health Services, which last year received an allocation of $152,000 from the United Fund Torch Drive, seeks to improve and coordinate the health facilities in the greater Philadelphia area and to fill the gaps in existing medical education, research and care.

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AMA Sets Rubella Guidelines

While rubella (German Measles) is generally a mild disease when contracted during childhood, in postpubertal individuals, particularly females, there is considerably greater potential for harm. The illness is often more serious and prolonged and not infrequently has complications such as arthritis, arthralgia, and rarely, encephalitis. In addition, when rubella is present during pregnancy, especially during the first trimester of pregnancy, but also during the second trimester, from 15 to 35 per cent of the infants may be born with what is now known as the congenital rubella syndrome. This includes partial or total loss of hearing or vision, major heart defects, mental retardation or combinations of these defects. In addition, there is a significantly increased proportion of miscarriages and stillbirths. Thus, serious transplacental damage is done by the virus.

The incidence of rubella shows a seasonal increase in the spring, generally during March, April and May in the United States, and these seasonal increases, in turn, have superimposed on them major national and international epidemics occurring at irregular intervals of from approximately six to nine years each.

In June, 1969, the first rubella vaccine was licensed in the United States. This was an attenuated live virus, manufactured by Merck, Sharp and Dohme.

Smith, Kline and French currently is manufacturing an attenuated live virus rubella vaccine from a different strain (Cendehill). This is grown on rabbit kidney cell culture in Belgium and probably will be licensed in the near future in the United States. It is very likely that prior to the next seasonal peak, which would be anticipated in spring, 1970, millions of doses of at least three different rubella vaccines will be available for use in the United States.

Vaccine Administration

The currently licensed vaccine is administered by a single subcutaneous injection of reconstituted lyophilized vaccine. The label and insert instructions should be carefully read and followed. The following precautions are recommended.

Pregnant women must not be given the vaccine because the viremia that follows vaccination and lasts two to six weeks may permit the virus to pass the placental barrier and affect the growing fetus.

If vaccination of a nonpregnant woman in the childbearing age is anticipated, special safeguards should be taken. These might include testing the woman to make sure she is not already immune to rubella* and would include carefully weighing the advantages of vaccine administration against the disadvantages, including the possibility of her becoming pregnant, with the likelihood that the fetus might miscarry or develop the congenital rubella syndrome. If the physician believes that vaccination is desirable, he should prescribe a medically acceptable method for contraception and should explain the potential risk of becoming pregnant to the patient, and, preferably, obtain written, informed consent for the vaccination.

Because of the possibility of placental transfer of maternal immune bodies and the likelihood of these interfering with the development of immunity following vaccination, it is recommended that the vaccine not be administered to children under one year of age. The presence of other virus diseases or any febrile active generalized infection, as well as the use of corticosteroids, irradiation, alkylating agents or antimetabolites or other agents that would weaken the normal defense mechanisms of the individual are contraindications to the use of rubella vaccine. Other contraindications include concurrent use of a different live virus vaccine (eg. measles or poliomyelitis). Administration of the rubella vaccine should then be deferred for at least four to six weeks.

For the Merck, Sharp and Dohme vaccine (Lyovac-Meruvax), epinephrine should be available for immediate use in case of an anaphylactoid reaction. The vaccine (which is grown on duck embryo cell culture) should not be given to individuals who are sensitive to duck or chicken eggs or feathers and, inasmuch as each dose of the reconstituted vaccine contains 25 micrograms of neomycin, individuals sensitive to this drug should not receive vaccine.

For widespread use, in view of the lack of adverse reactions in small children and the fact that about two-thirds of the children under ten would be susceptible, all should receive the vaccine without doing a preliminary serological test for susceptibility. Children in kindergarten and the early grades of elementary school deserve initial priority for vaccination because they are commonly the major source of virus dissemination in the community. A history of rubella illness is usually not reliable enough to exclude children from immunization.

In view of the fact that circumstances will differ in various localities, it is recommended that group programs and public health programs should be launched on the basis of a coordinated plan, developed jointly by state and local public health agencies in cooperation with state and local medical and osteopathic associations.

**The only reliable evidence of immunity is a positive serological test. However, because of the variation among reagents and technical procedures, results of serological tests should be accepted only from laboratories of recognized competency that regularly perform these tests.*

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close-up/MD's

J. Scott Martin, M.D. has been appointed to the permanent staff of The Geisinger Medical Center in association with **Henry Hood, M.D.,** director of neurosurgery. Dr. Martin is a native of Pennsylvania and graduated from the University of Pittsburgh School of Medicine. He interned at Shadyside Hospital in Pittsburgh and practiced in Louisiana and Utah. In Utah he was on the staff of the student health service at Brigham Young University.

DR. MARTIN

Samuel S. Morrison, M.D., director of pediatrics at The Geisinger Medical Center, has been elected president of the Pediatric Society of Northeastern Pennsylvania for the year 1969-70. **Thomas E. Cadman, M.D.,** associate in pediatrics and pediatric neurologist at the center, has been chosen vice president of that organization.

DR. MORRISON

Monto Ho, M.D., professor on the faculty of the University of Pittsburgh Graduate School of Public Health, has been appointed chairman of the school's department of epidemiology and microbiology. Announcement of the appointment was made by Dr. Herschel Griffin, dean. Dr. Ho will succeed **William Hammon, M.D.** who has recently retired as chairman of the department but will continue to serve on the faculty.

John F. Ditunno, Jr., M.D., Philadelphia, has been appointed professor and head of the newly established department of rehabilitation Medicine, at the Jefferson Medical College, Thomas Jefferson University, it was announced by **William F. Kellow, M.D.,** dean and vice president. Dr. Ditunno was director of clinical management division of physical medicine and rehabilitation at Temple University Hospital and associate professor of Temple University Medical School.

Glen R. Leymaster, M.D., president and dean, Woman's Medical College of Pennsylvania, announces the appointment of **Ethel Weinberg, M.D.,** as assistant dean. Dr. Weinberg joined the college in 1967 as assistant to the dean to head the school's pioneer program to retrain women physicians, who had dropped out of active practice to care for their young children or for other personal reasons. According to Dr. Leymaster, Dr. Weinberg, "in addition to directing the retraining program, will work closely with **Mary Ellen Hartman, M.D.,** associate dean, and **Eva Fox, M.D.,** chairman of the curriculum committee, to implement the reorganized fourth year curriculum.

DR. WEINBERG

Allen W. Root, M.D., Philadelphia has been named full-time chairman of the division of pediatrics at Albert Einstein Medical Center, and associate professor of pediatrics at Temple University School of Medicine, with which the medical center is affiliated. Dr. Root came to Einstein from his post as associate physician and endocrinologist at the Children's Hospital of Philadelphia. He had held that responsibility at Children's as well as the position of assistant professor of pediatrics, University of Pennsylvania School of Medicine since July, 1966.

Clark E. Brown, M.D., has retired as director of Lankenau Hospital's division of pathology. He occupied the post for twenty-four years. From 1965 to 1968 he also served as acting director of Lankenau's division of research, and was president of the medical staff from 1958-60. He is also professor of pathology at Jefferson Medical College.

A former York physician of thirteen years, **Thelbert R. Moyer, M.D.,** returned to York Hospital recently from a leave of absence, to head the newly organized physical medicine and rehabilitation department. This department incorporates the former physical therapy department and is involved with the stroke unit. Prior to entering general practice in 1954, Dr. Moyer earned his medical degree at Hahnemann Medical College, and served his rotating internship at York Hospital and joined the medical staff. In the summer of 1967, Dr. Moyer took a leave of absence to complete a residency in physical medicine and rehabilitation.

DR. MOYER

The first Duncan Graham Award for "distinguished service and contribution in the field of medical education" has been awarded to **John P. Hubbard, M.D.,** president and director of the National Board of Medical Examiners, Philadelphia. The award, to be given annually by the Royal College of Physicians and Surgeons of Canada, honors Dr. Duncan Graham, Emeritus Professor of Medicine, University of Toronto.

A fifth physician has been appointed to the department of family and community medicine at The Milton S. Hershey Medical Center of The Pennsylvania State University. **Frank C. Snope, M.D.,** has been in private practice in Lebanon, N.J. and associated with the Hunterdon, Medical Center. At Hershey he will hold the rank of assistant professor.

(Cont'd. on Page 66.)

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Specific reports on the hematopoietic system include twa each af bone marrow depression, agranulocytasis, ond leukopenia.

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close-up/MD's

Bernard B. Zamostein, M.D., of Philadelphia, was installed as president of the Pennsylvania Academy of General Practice at the organization's twenty-first Annual Scientific Assembly. **Robert G. Hale, M.D.,** of Lafayette Hill, was named president-elect, to take office next year. Newly elected officers installed with Dr. Zamostein were vice president, **David W. Kistler, M.D.,** of Wilkes-Barre; secretary, **F. Wendle McLaughlin, M.D.,** of Lancaster; and treasurer, **John J. Hanlon, M.D.,** of Mechanicsburg. The Pennsylvania Academy of General Practice, with a membership of over 1500 family physicians, has been active in increasing the supply of comprehensive and continuing medical care to all members of the family unit by its members. It is at present the only medical organization that requires continuing postgraduate education and study as a requirement for continuing membership.

DR. ZAMOSTEIN

Gerald R. Clark, M.D., president of Elwyn Institute, Elwyn, recently was named "physician of the year" by the Governor's Committee on Employment of the Handicapped. The committee said he was selected in recognition of the exceptional contributions he has made in aiding the mentally, emotionally and socially ill and returning them to useful, productive lives. Dr. Clark served for three years as Pennsylvania's first commissioner of mental retardation, on leave from his post at Elwyn, an institution for the mentally retarded which has a record of returning 200 of its 1,300 students each year to independent community living. Announcement was made recently of groundbreaking for a new building at Elwyn to serve the needs of children with minimal brain dysfunction.

John R. Liska, M.D., Greensburg, has been elected president of the Urological Association of Pennsylvania. Serving with him are: **Robert H. Bradley, Jr., M.D.,** Philadelphia, president-elect and **Josiah F. Reed, Jr., M.D.,** Harrisburg, secretary.

Eugene N. Myers, M.D., assistant professor of otolaryngology at the University of Pennsylvania School of Medicine was visiting professor of otolaryngology at the University of Nebraska Medical Center recently, lecturing on "Histopathology of the Human Temporal Bone," and on "Reconstructive Surgery on the Head and Neck Following Resection for Cancer."

Robert N. Swenson, M.D., assistant professor of medicine and microbiology and a former advanced research fellow of the American Heart Association, will head the new section on infectious diseases in the Temple University School of Medicine's department of internal medicine. He is a graduate of the Washington University School of Medicine. "Infectious diseases are a major problem in a hospital, and we have been lacking a section on infectious diseases for some time," **Sol Sherry, M.D.,** professor and chairman of the division of medicine, said.

Elsie R. Carrington, M.D., Philadelphia, has been elected president of the Obstetrical Society of Philadelphia. Serving with her are: **Harry Fields, M.D.,** president-elect; **James D. Garnet, M.D.,** first vice-president; **Edward J. Murphy, M.D.,** second vice-president; **John J. Mikuta, M.D.,** secretary, and **Joseph J. Price, M.D.,** treasurer.

Elias Schwartz, M.D., associate professor of pediatrics, Jefferson Medical College, has received a grant for the study of "Heme and Globin Synthesis in Infants and Children." The grant, from the National Institutes of Health, is for $78,000.

George Lasota, M.D., has been appointed staff psychiatrist at Friends Hospital, Philadelphia. A graduate of St. Joseph's College and Jefferson Medical College, Dr. Lasota took his internship at Meadowbrook Hospital, Long Island and his residency at Philadelphia Psychiatric Center. He practiced at the Air Force Hospital in Wichita Falls, Kansas, and later became a Fellow of the Temple University Unit in Law and Psychiatry. He is a member of the faculty of Hahnemann Medical College and Hospital department of psychiatry.

Edward R. Burka, M.D., associate professor of medicine at Jefferson Medical College and chief of the hematology clinic at Thomas Jefferson University Hospital has been appointed director of the blood bank at the hospital. Dr. Burka, who has been associated with Jefferson and the Cardeza Foundation for Hematologic Research since 1966, is a graduate of Princeton University and the College of Physicians and Surgeons, Columbia University, where he was elected to the honorary societies of Alpha Omega Alpha and Sigma Xi.

DR. BURKA

Daniel Blain, M.D., director of Philadelphia State Hospital, Byberry, delivered the keynote speech on "The Effective Use of Limited Manpower Resources," at the Institute for Hospital and Community Psychiatry in Houston, Texas, recently. A past chairman of the manpower commission of the American Psychiatric Association, Dr. Blain headed one of the six sections of the institute, which was attended by some 800 professionals from state mental hospitals and community mental health centers across the country. **Franklyn R. Clarke, M.D.,** Byberry's assistant director in charge of patient care, and James B. Miller, hospital administrator, also attended the institute. Dr. Blain filled speaking engagements in the Los Angeles area in recent weeks, and is scheduled to speak at Cleveland (O.) State Hospital this month on how Philadelphia State Hospital halved its patient population in the last three years to its present 3,200, and is rebuilding its reputation as a therapeutic institution.

Newly elected officers of the District Three Junior Fellows of the American College of Obstetrics and Gynecology are **Allan Beer, M.D.,** Philadelphia, president; **Palmer Evans, M.D.,** Philadelphia, president-elect; **Bruce Viechnicki, M.D.,** Allentown, vice-president, and **Edward D. Bernstein, M.D.,** Pittsburgh, secretary-treasurer.

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Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

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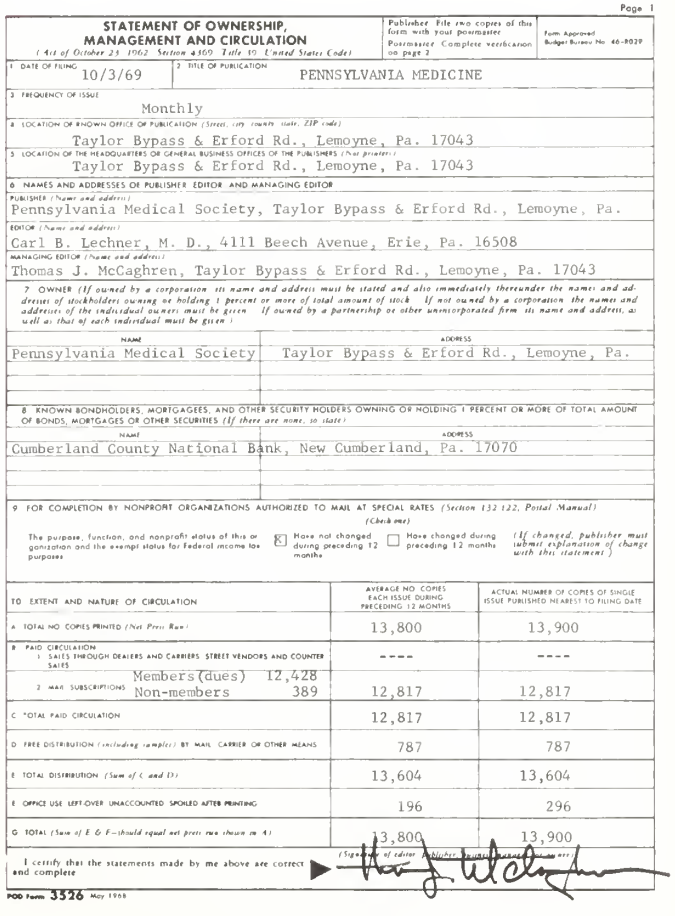

Page 1

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In the Commonwealth

Senate Passes Professional Corporation Bill

Senate Bill 1005, the so-called professional corporation law, was passed unanimously by the State Senate last month, and has moved into the House of Representatives. If passed by the House, it would permit professionals, physicians, dentists, lawyers, engineers, etc., to incorporate under the laws governing corporations in Pennsylvania, and take advantage of the laws governing business corporations.

House Bill 2, the uniform anatomical gifts act, is now before the Senate, having been passed by the House of Representatives during the early months of this session. The Senate Committee on Public Health and Welfare has added several amendments which weaken the bill, but do not create irreparable harm. They are: (1) anatomical gifts must be made in writing by the individual at least fifteen days before the date of death, and it raises a question as to the validity of gifts to be made by the next of kin; (2) a donor who is mentally competent, but physically unable to write, may order the document signed by another person in the presence of two witnesses who also would sign the document; (3) if a donee accepts an anatomical gift of an entire body, he shall, subject to the terms designated by the donor, authorize embalming and use of the body in funeral services.

This last amendment, suggested by the Funeral Directors Association of Pennsylvania, changed the language from the permissive "may" to "shall."

In the House of Representatives a measure permitting minors over eighteen years of age to donate blood on their own recognizance was passed by a vote of 189 to 10. This bill can have far-reaching effects, if passed by the Senate, because it permits the legislature to lower the age of consent in some instances from twenty-one to eighteen. The bill has been forwarded to the Senate Committee on Health and Welfare.

Senate Bill 254, calling for coverage of chiropractic care by Blue Shield has remained in committee in the House of Representatives, despite a major effort by chiropractors and their friends to have it released. Blue Shield has informed the committee of the recommendations made by its state-wide subscribers advisory council. The council compiled a list of services which should be covered prior to any inclusion of chiropractors. The list, which is long, gave high priority to: prescription drugs, comprehensive office diagnostic or psychiatric treatments, post-natal care, private duty nursing, medical appliances, ambulance, physiatry, home calls, orthodontia and periodontia, etc.

In the Nation

HEW Establishes Standards for TV

A proposed standard to establish a maximum level for television receiver X-ray emissions has been announced by the Department of Health, Education, and Welfare.

The proposal, published in the Federal Register, was issued by HEW's Environmental Control Administration under the Radiation Control for Health and Safety Act.

It would apply to TV sets coming off assembly lines after January 1, 1970, and is expected to be the first standard to be promulgated under the Act. The law authorizes performance standards for the control of radiation from all types of electronic products.

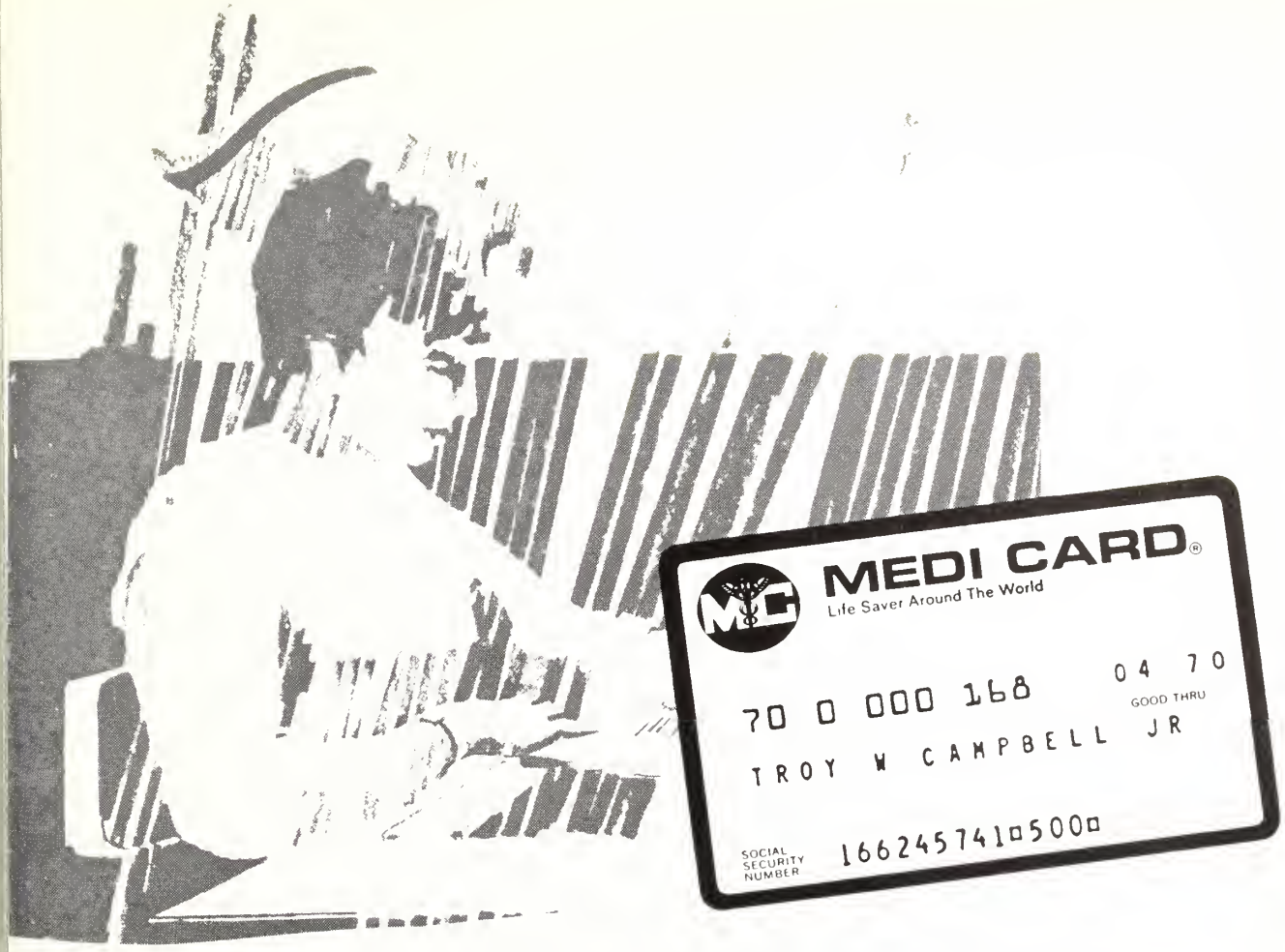
The standard would become effective upon republication in the Register after at least thirty days have been allowed for public comment.

The proposed standard would limit X-ray emissions to a maximum of 0.5 milliroentgen per hour five centimeters (about two inches) from any external surface of a set operating at a maximum of 130 line volts under three operating conditions each of which has a high X-ray generation potential. Receivers would have to be manufactured to meet the maximum under all three operating conditions on the following schedule of deadlines:

1. Sets produced after January 1, 1970, should be capable of meeting the 0.5 milliroentgen per hour standard at maximum electric power line voltages even though a set owner accidentally should maximize the receiver's X-ray emission potential by maladjusting external controls. High line voltages, irrespective of external control maladjustment, have been found to be a cause of excessive TV set X-ray emissions.

2. Sets produced after June 1, 1970, should be capable of complying with the standard with both external and internal controls adjusted to maximize X-ray emission potentials. Increases in picture tube high voltage settings, for example, have resulted in excessive X-ray emissions.

3. Sets produced after June 1, 1971, should not emit X-radiation above 0.5 milliroentgen per hour in event of a component or circuit failure which would maximize the X-ray emission. Compliance with this condition might require the production of receivers with devices for shutting off the set or limiting high voltage when a critical circuit fails.



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Less than one-third of the physicians of Pennsylvania support the political activity of organized medicine in our Commonwealth. This is among the most flagrant cases of disregard of enlightened self-interest which has come to my attention. The profound activity of all levels of government in medical practice is now common knowledge. It is matched by similar activity in medical education, in medical research, as well as in the distribution of physicians and many other activities concerned with health care. And government involvement can only increase.

Do you who fail to support our political action effort really want to have no voice in the selection and decisions of those political bodies who are determining your future? There are plenty of examples of other organizations whose political action groups are effectively promoting the advantages of their members and constituents. Are we physicians to be left without a voice in this forum of political action? Are we to go on with mere token support of AMPAC and PaMPAC—organizations whose efforts in political education would, alone, be well worth every cent and every erg of effort we have invested in them?

Let us look at the matter from the viewpoint of a devil's advocate. If there were no PAC movement, the more than two-thirds of physicians who fail to support it would certainly contain the great majority of those who would be crying in the political wilderness: "Why cannot our Medical Society have some kind of organization to teach us how to look after our political interest?"

Medicine does not exist in a vacuum. It is a part of the life of our times and this certainly includes political life. If *you* are not contributing time, effort and money to your state and national Political Action Committee, you are ignoring your own interest. You are also taking advantage of those physicians who *are* contributing, since you are riding on their political coattails.

Even a cursory study of the position of organized medicine in American life will convince you that we must have a political action organization. And the more members who become involved, the more effective it will be. We need much more involvement and it must be as deep as it is wide.

CBL

Poet and Physician

The eyes of a nation's poets see what we all see but the mind's eye of the poet perceives with a clarity which is unique. As a result, his works can take us with him so that we may also penetrate to the heart of the matter. We physicians, in our modern quandary of social and economic revolution, can well use such clarity of vision and such poetic insight.

Our distinguished American poet, W. H. Auden, has done such a service for doctors by publishing his poem, "The Art of Healing" in *The New Yorker* of September 27, 1969. In this writing, Mr. Auden, whose father was a physician, shows an extraordinary sensitivity toward our profession as well as a similar understanding of the needs and reactions of the patient.

The poem is a tribute to Mr. Auden's personal physician and is subtitled, *In Memoriam David Protetch, 1923-1969*. Few physicians achieve such a tribute! We all are aware that patients tend to develop a high regard for their own doctors and that they sometimes praise them.

But few physicians are given an encomium like that of Auden's poem. How many of us can expect to be called, even posthumously, "what all doctors should be but few are"?

For us, in practice, the poem may serve, as no other kind of writing can serve, to tell us that we are not driving a trade but are practicing a profession which calls for nobility of character. Even the best of us can well afford to hear this stated in so moving a fashion.

CBL

A Bow To Organized Pharmacy

The United State Pharmacopeia will celebrate its one hundred fiftieth anniversary next year. It has an illustrious record and the rare event deserves the attention of every medical practitioner. It represents the concerted effort of two distinguished professions, medicine and pharmacy, now often under attack by a public which is in need of better information. *(Continued on page 75.)*

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REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32, 1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

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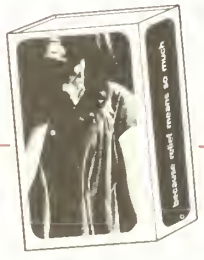

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editorials

This sesquicentennial offers an opportunity to the physician to acknowledge his indebtedness to the profession of pharmacy as well as a chance to recognize publicly the need for continued and increasing cooperation at professional and socio-economic levels.

For more than thirty-five years organized pharmacy has sought the issuance of a commemorative stamp, honoring the profession of pharmacy. There is evidence that this effort now has a good chance of success.

To pay tribute and honor to this sister profession the physician may take this opportunity to support the issuance of such a commemorative stamp. It is necessary only to write an appropriate letter of request to his congressman. Such an opportunity for expressing our solidarity of interests and action ought not to be missed. CBL

Medical Education and Licensure

"Next in importance to Freedom and Justice is Education without which neither Freedom nor Justice can be permanently maintained." James G. Garfield

The withdrawal of our Pennsylvania State Board of Medical Education and Licensure from the *Federation of State Medical Boards of the United States* is a cause for concern to any physician who is aware of organized medicine's need to meet the stress of the changes in our time. The importance of education and of a "balance between accreditation, certification and licensure" [1] is high on the list of factors which require our attention in the bases of the challenges of change. The relationships of our State Board to the problems of licensure of paramedical professionals and technicians is another subject of major importance as is the place of these important workers in the health care pattern. The question of the status and legal position of the military medical corpsman who takes a place in civilian health care also merits the concern of the state board.

Nothing in our medical lives has seen more innovation, more experimentation and more activity than the educational process of becoming a physician. Medical school curricula are doing violence to the ancient and outmoded state laws under which most of our state boards must function. The new physician's first year of graduate education in the hospital may well not fit the definition of "internship" required by existing laws. In short, there are many and growing problems in medical education and licensure. We need the best board we can get and the board needs all the consultation and information it can get.

For this reason it seems that our Pennsylvania state board should not abandon such a splendid forum for discussion and study on the national scene as is afforded by the federation of state boards. The opportunity for valuable contacts and information are alone worth the few hundreds of dollars of expense which is cited as the major reason for withdrawal from the federation. Furthermore, our state can certainly afford the cost of sending representatives to the federation meetings and to the meetings of its committees.

There seems, indeed, to be some cause for seeking improvement in some of the activities of the Federation. But the remedy for this would appear to be continued membership and more attempts at additional participation and reform from within. Complete withdrawal is not likely to be an effective maneuver and can never give our state board a national forum for discussion of the solutions to the problems we face.

Pennsylvania has continued to use examinations for licensure which are purchased from an outside source. It would appear that the board should seriously consider the use of the Federation Licensing Examination—FLEX. In the Walter L. Bierring Lecture in February 1969, Dr. Dwight Wilbur [1] cited these advantages of FLEX: (1) it involves more of an attempt to measure the clinical competence of the applicant, (2) it is an examination of the licensing boards themselves rather than a product of a separate outside corporation, and (3) it will make reciprocity among the states easier by facilitating the interchange of medical licenses that represent more uniform testing procedures.

Dr. Wilbur acknowledges that different standards for grading the FLEX papers might be "a small problem" in granting reciprocity. But, again, this seems to indicate that we need more work, more experimentation and more consultation within the Federation, rather than withdrawal.

Our State Board should rejoin the Federation, judging by all the criteria we can find, in order to improve Medical Education and to attain better and more uniform methods of determining the quality of the physicians who will practice in Pennsylvania. CBL

REFERENCE

1. **Wilbur, Dwight L.:** A New Look at Licensure. The Walter L. Bierring Lecture. Federation Bulletin 56; 111-120. May, 1969.

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The Simple Clinical Evaluation of Renal Function

DONALD G. VIDT, M.D.
Cleveland, Ohio

Clinical tests of renal function may be divided into three general groups: (1) tests that estimate the overall efficiency of the kidney but give few clues to diagnosis, (2) tests that help to establish the diagnosis, (3) tests that measure differentially the function of each kidney.

Most of the common generalized renal diseases present a similar pattern of impairment of renal function (fig. 1) and cannot be distinguished on the basis of simple clinical tests. Yet, the most precise tests for measuring various aspects of renal function are too time consuming and cumbersome for general office or clinical practice. The ideal renal function test should be safe, accurate yet simple to perform, need no elaborate laboratory facilities, and should be specific in that the results are affected only by changes in renal function. None of the five tests discussed in this paper meet the ideal specifications, yet when used singly or in combination, these five simple tests (Table 1) provide valuable information in regard to the overall adequacy of renal function. These clinical tests will help the physician to establish the presence (or absence) of renal disease, to estimate the prognosis of some diseases, may help to determine the potential risk of surgical procedures, and may be used to evaluate the course of established renal disease.

Table 1.—Five Simple Tests of Renal Function

1. **Urinalysis**
2. **Serum creatinine concentration**
3. **Endogenous creatinine clearance**
4. **Phenolsulfonphthalein clearance (PSP test)**
5. **Urinary concentration test**

1. Urinalysis can provide critical information about the presence or absence of renal disease. The introduction of simple, yet sensitive methods for the detection of protein, glucose, and bacteria have made urinalysis a reliable indicator of the presence of latent disease. The urine is best examined by the physician responsible for the patient, and a properly collected midstream specimen is most suitable for examination since it avoids contamination by prostatic or vaginal secretions and the risk of ascending infection induced by catheterization. Proteinuria may be recognized by precipitation with sulfosalicylic acid, by boiling urine after the addition of acetic acid, or by the color changes induced in one of the several commercially available dip sticks. Careful timing of the chemical reaction is important with the latter method. Benedict's solution or reagent tablets

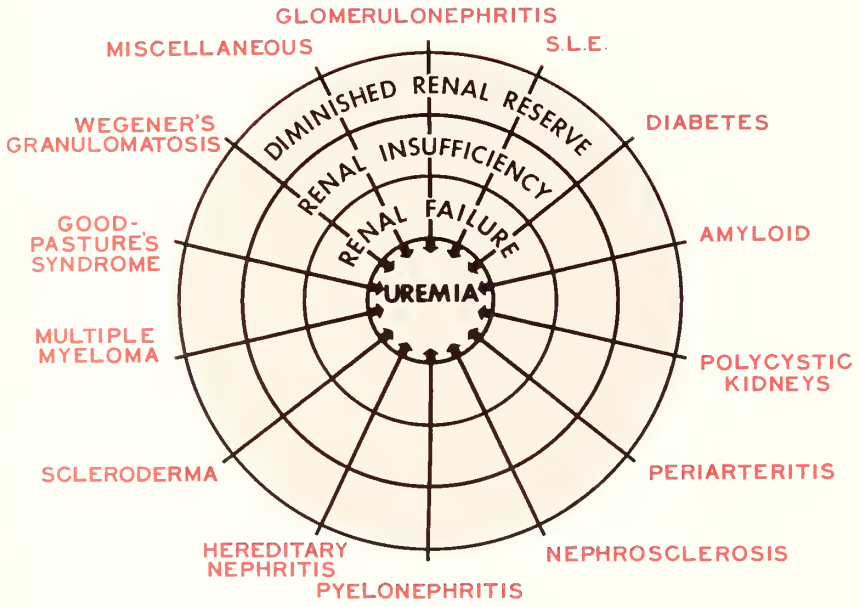


Fig. 1. *The pattern of renal function impairment in the more common renal diseases.*

It will be seen that a similar pattern of progressive renal functional loss is seen in many different renal diseases with uremia being the end result.

detect numerous reducing substances in the urine beside glucose, while special testing tapes or dip sticks impregnated with glucose oxidase are specific for glucose. There are several methods adaptable to office use, which will reportedly detect the presence of significant numbers of bacteria in the urine. I find it simpler to stain a drop of freshly voided urine with Gram's stain. If bacteria are seen on the smear it can be presumed that the urine contains 100,000 or more organisms per milliliter of urine. A clean voided midstream urine culture is of more value in the diagnosis of urinary tract infection than is the qualitative Gram stain.

Simple observation of the color of the urine may reveal the characteristic shades induced by bilirubin, blood, porphyrins, food or drug colorings; and the characteristic odors of certain amino acids may be pathognomonic of certain metabolic disorders.

Qualitative examination of the urinary sediments is of limited value. The urine specimen is centrifuged at 3,000 rpm for five minutes and an abundant sediment is resuspended in ½ ml of supernatant fluid. When the sediment is scanty the plug may be pipetted and spread upon the slide. Hematuria must be considered in regard to many disease processes of the genitourinary tract, whereas the finding of erythrocyte casts confirms the parenchymal origin of the blood cells. Erythrocytes or free hemoglobin in the urine will produce a positive color reaction with benzidine, guaiac, and the dip stick (ortho-tolidine) tests. One important point to remember is that erythrocytes will lyse in a quite dilute urine and hemoglobin will be liberated into it. Clumped leukocytes may be considered pathognomonic of infection, oval fat bodies or fatty casts indicative of renal parenchymal disease, while "broad casts" may be indicative of advanced renal failure. The persistence of proteinuria on repeated urinalyses can be ascribed to systemic disease or to intrinsic renal disease, and the use of simple laboratory procedures will confirm or negate the presence of Bence Jones protein or another abnormal globulin.

Normally, the specific gravity of the urine ranges from 1.003 or less to 1.020 or more. The use of urine specific gravity as a test of renal function is considered later in this discussion. The hydrogen ion concentration (pH) of the urine is best tested in a freshly voided specimen with

phenaphthazine paper. Healthy kidneys can produce urine with a wide pH range (from 4.4 to as high as 8), although normally, the urine is usually acid. Persistently alkaline urines occur in association with infections caused by certain urea-splitting bacteria, but may also follow the ingestion of sodium bicarbonate or other alkalinizing drugs, as well as the ingestion of oral diuretics.

2. Serum Creatinine Concentration: It is common to rely upon the blood urea nitrogen (BUN) value as an indicator of renal function. Unfortunately, the BUN is neither specific nor sensitive and does not increase beyond the normal range until glomerular filtration rate has declined by as much as 60 per cent (Fig. 2). Furthermore, the BUN is determined not only from the net effect of glomerular filtration and tubular resorption of urea nitrogen, but also from the rate of urea nitrogen production. Therefore, a number of extrarenal factors, such as dietary protein intake, state of hydration, and hepatic function, help determine the level of the BUN, and may result in significant shifts up or down on the curve in Figure 2. Much more specific than the BUN is the serum creatinine concentration. It is largely independent of diet, is influenced mainly by muscle mass, and remains relatively constant at any specific rate of glomerular filtration. The major limitation in the use of serum creatinine concentration, as with the BUN, is the fact that it provides no indication of renal impairment until the renal clearance has been substantially reduced (Fig. 3). As is discussed next, a more practical means of estimating glomerular filtration rate is the measurement of endogenous creatinine clearance.

3. Endogenous Creatinine Clearance: Endogenous clearance methods provide a quantitative expression of the rate at which the kidneys excrete various substances relative to their concentrations in the plasma. The clearance of any substance by the kidney can be determined if the plasma concentration is measured along with the rate of urinary excretion of that substance in milligrams per minute. The precise measurement of glomerular filtration rate is usually obtained by determination of the inulin clearance which is, however, impractical for standard clinical practice.

The endogenous creatinine clearance provides the most practical meth-

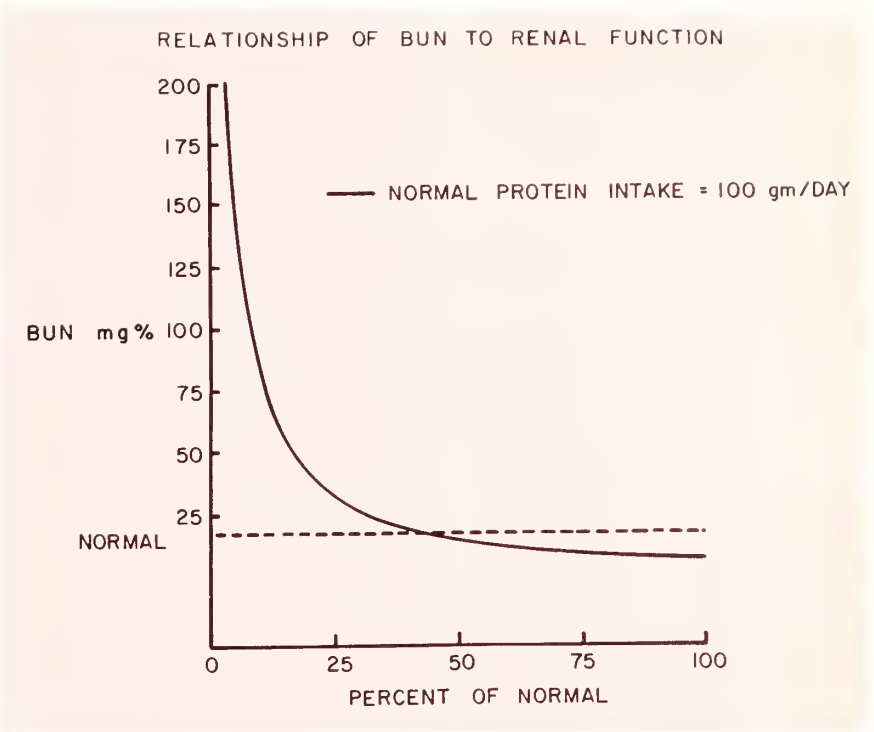
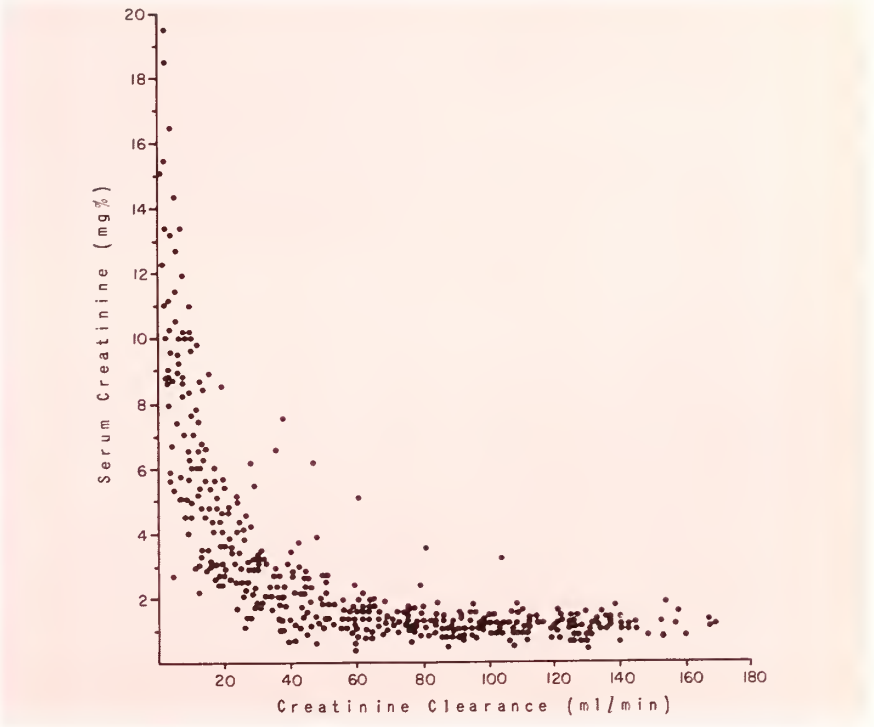


Fig. 2. *Above. The relationship of BUN to renal function.*

It will be seen that significant impairment in renal function is present before the BUN is elevated above the normal range. The curve may be shifted significantly up or down depending upon the extrarenal factors influencing the rate of urea nitrogen production.

Fig. 3. *Below. The relationship of serum creatinine concentration to creatinine clearance.*

It is seen that an excellent relationship exists over a wide range of renal function, and this relationship is little affected by extrarenal influences.



od for estimating glomerular filtration rate and comes nearest to fulfilling our criteria for the ideal renal function test, despite the fact that it measures both glomerular filtration and tubular secretion of creatinine. It has definite advantages over the more popular urea clearance test since it does not vary with the rate of urine flow, and, as discussed earlier, is not affected so much by extrarenal factors. The rate of creatinine excretion remains relatively constant over short periods, and correlates well with simultaneously determined inulin clearance over a wide range of renal function. In severe renal insufficiency the ratio of the creatinine clearance to inulin clearance tends to exceed 1, reflecting tubular secretion of creatinine. Although the creatinine clearance may be from 10 to 30 per cent higher at low glomular filtration rates, the absolute differences are small (i.e., a clearance of creatinine of 13 ml per minute equals a clearance of inulin of 10 ml per minute).

The endogenous creatinine clearance is particularly useful as a prognostic guide, since its ease of determination and accuracy of results over a wide range of renal function (Fig. 3) allow serial determinations to follow the course and progression of established renal disease. Since plasma creatinine content does not fluctuate widely or rapidly, the creatinine clearance can be determined from 12- or 24-hr. urine collections, which greatly minimizes the errors attendant upon collection of brief, timed, urine specimens.

4. Phenolsulfonphthalein Clearance (PSP Test): Although the clearances of Diodrast and PAH (para-amino hippurate) are the standards of reference for the accurate measurement of renal plasma flow, the PSP test when properly determined provides an approximation of renal plasma flow. PSP is remarkably nontoxic, is not metabolized, and is largely excreted by the kidney. The rate of excretion is proportional to the plasma concentration, thus the excretion rate is greatest immediately after injection when the plasma level is highest. Normal adults may clear from 35 to 50 per cent of PSP in fifteen minutes after injection, and from 60 to 85 per cent of the injected dose in two hours. In early renal impairment, the fifteen-minute PSP excretion may be reduced, whereas when time for repeated recirculation is allowed, the two-hour excretion may be normal. Therefore, the fifteen-minute specimen is by far the more valuable and is the only specimen needed to provide an approximation of renal plasma flow.

There are numerous opportunities for misinterpreting PSP clearance. Errors are surprisingly common in the timing of urine collections, and it is important that the patient be well hydrated before the test, so that he may voluntarily empty the bladder completely precisely fifteen minutes after the intravenous injection of 6 mg of PSP. Residual urine in the upper urinary tract or bladder leads to a falsely low result. In fact, the PSP clearance may be used as an indirect test to detect urinary retention. The patient voids completely thirty minutes after PSP injection. If 50 per cent or more of PSP is excreted in the first half hour, the patient is not retaining urine and likely has good total function. If he fails to excrete 50 per cent he may be retaining urine or else impaired renal function has limited the excretion of dye. A second specimen is then collected thirty minutes later, and the percentage of PSP excretion is calculated as before. A greater percentage of PSP in the second specimen (represented by an uphill curve) suggests urinary retention. PSP excretion may be impaired if performed within eight to twelve hours after an intravenous urogram, because of competition for the same tubular excretory mechanism. Probenecid may also reduce PSP excretion by the same mechanism. Drugs such as nitrofurantoin, pyridium and sulfobromophthalein (BSP) interfere with the colorimetric determination of PSP.

5. Urinary Concentration Test: Measurement of the specific gravity of the urine after a period of dehydration provides an extremely simple, yet reasonably accurate assessment of tubular function. Impairment in the ability to concentrate the urine to a normal degree is an early feature of most generalized renal diseases that may be detectable by this test even when results of other tests of renal function still are normal. The test loses its sensitivity when glomerular filtration rate has decreased to 20 per cent of normal, since urinary osmolality (or specific gravity) becomes relatively fixed at a value similar to that of the plasma. No special diet is necessary as long as adequate protein and salt intake are insured. A specific gravity of more than 1.023 obtained on any random specimen of urine or after overnight dehydration indicates normal tubular function. Twenty-four hours of dehydration or even longer periods may be required to attain a maximum specific gravity. To avoid prolonged fluid deprivation, five units of pitressin tannate in oil administered intramuscularly will obtain comparable urinary concentration.

Misleading results will be obtained in patients with unrecognized proteinuria or glucosuria, although meaningful values may still be obtained by using correction factors. Heavy glucosuria may induce solute diuresis, which invalidates the concentration test. Erroneous readings may also result from imprecise calibration of the hydrometer, or failure to correct the readings for temperature changes, or during the diuresis of edema fluid or critical electrolyte depletion associated with the administration of potent diuretics. Other nonrenal influences on the ability to concentrate urine include diets persistently low in protein or salt, or a habitually high fluid intake as practiced by some patients. It is not uncommon to see the specific gravity inadvertently determined on urine specimens after an excretory pyelogram or other angiographic procedures. Also to be kept in mind are the lack of production of antidiuretic hormone by the pituitary, or the rare patient with nephrogenic diabetes insipidus. When these limitations are kept in mind, the urinary concentration test provides an accurate assessment of the adequacy of renal tubular function.

In summary, the overall efficiency of renal function can be estimated by the performance of several simple clinical tests. A carefully performed urinalysis will provide invaluable information regarding the presence of renal disease, while the serum creatinine concentration and the endogenous creatinine clearance, PSP excretion, and the urinary concentration test provide an adequate clinical assessment of renal excretory function. Specific diagnosis will depend upon other studies, such as intravenous urography, pyelography, selective renal angiography, or renal biopsy.

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Protective Value of Suboptimal Arterial Blood Pressure on Renal Function

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An acute reduction in arterial blood pressure such as occurs in shock due to various causes is often followed by impairment of renal function. Undoubtedly renal ischemia caused by the resulting decrease in renal blood flow contributes to renal damage under these circumstances, but the contribution of other factors must also be taken into account. The deleterious effects of the conditions causing shock cannot, however, be readily separated from those of the hypotension itself.

In order to evaluate the effects of hypotension alone on renal function in man, we have investigated renal hemodynamics during cardiopulmonary by-pass. This procedure provides an excellent opportunity to determine the effect of decreased mean arterial blood pressure in the distal aortic segment on renal function. Our report presents the recorded data on eight patients who underwent aortic by-pass for resection of aneurysms of the thoracic aorta. Mean blood pressure, renal blood flow, and glomerular filtration rate were monitored in these patients to determine their correlations. The information obtained should be helpful in estimating the prognosis for patients who have experienced transient acute hypotensive episodes.

Methods

Eight patients who had aneurysms of the descending thoracic aorta were randomly selected for inclusion in the study. Their ages ranged from forty-two to sixty-four years. Temporary extracorporeal circulation was utilized

Patient No.	Age	Race Sex	Occlusion Time (Minutes)	Mean Pump Flow Rate (cc/min.)	Mean Blood Pressure (mm. Hg)						Renal Blood Flow (cc/min.)					Glomerular Filtration Rate (cc/min.)				
					C	C_1	S Up.	S Low.	S_1	F	C	C_1	S	S_1	F	C	C_1	S	S_1	F
1*	51	W F	28	1275	116	118	130	46	128	‡	455	365	44	500	‡	50	42	8	40	‡
2	62	W M	45	1240	114	116	130	44	--	118	648	668	30	--	630	69	46	2	44	71
3	64	W M	56	1250	104	116	126	40	118	92	640	970	30	610	820	81	86	12	56	66
4	54	W M	60	410	100	100	112	32	86	100	894	409	0	440	820	90	64	4	30	51
5*	42	W F	27	1150	98	102	94	44	100	‡	800	432	390	246	‡	70	50	10	10	‡
6	43	C F	35	1300	100	126	124	36	110	98	790	586	11	1102	800	112	52	4	60	110
7	61	C M	42	825	123	120	124	42	116	90	920	460	30	1140	940	146	11	4	94	105
8	44	W M	43	1150	93	84	106	44	85	93	1356	1494	30	1806	1822	143	136	3	88	160
Mean:	55		46	1062	106	110	120	40	103	99	875	765	22	1020	972	107	66	5	62	94
Percent of Control:					--	104	114	38	97	93	--	87	3	117	111	--	62	5	58	88
P =										>0.05#					>0.05#					>0.05#

Key to Abbreviations:
C = Before operation
C_1 = During thoracotomy before occlusion of the aorta
S = During occlusion of the aorta alone (Up. = upper extremity; Low. = lower extremity)
S_1 = After occlusion of the aorta with pump running
F = Following operation

Footnotes:
*Note -- Cases 1 and 5 are not included in computations.
‡ Patient expired.
# Not significant by Analysis of Variance [2] (for F compared to C)

during resection of the lesions. This was accomplished by placing one catheter proximally in the left atrium and another distally in one common femoral artery, and connecting the catheters to 3/16 inch polyvinyl tubing, with a Sigmamotor pump interposed to control the flow rates.

Mean blood pressures during by-pass were determined directly by means of a water manometer attached to a 15-gauge needle inserted into the distal aorta. Mean blood pressures at all other times were obtained by auscultatory methods, the values being determined by adding one-third the pulse pressure to the diastolic pressure. Inulin and para-aminohippurate clearances were used to estimate glomerular filtration rate and renal plasma flow, respectively, using previously described techniques.[1] Renal blood flow was calculated from renal plasma flow with the hematocrit.

Observations of mean blood pressure, renal blood flow, and glomerular filtration rate were made before operation, during thoracotomy before occlusion of the aorta, during occlusion alone, while the aorta was occluded with pump running, and following operation.

Statistical analysis was performed on a CDC 6400 computer, using BMD 08 V Analysis of Variance, version of September 1, 1965.[2]

Results

Observations made during each period on each patient in the series are recorded in the table. Patients 1 and 5 have been excluded from the discussion. Patient 1 was in poor condition at the time of the procedure, and the aneurysm ruptured; patient 5 showed poor response to the pump by-pass and died.

Total occlusion times varied from thirty-five to sixty minutes, with mean pump flow rates of 410 to 1300 cc. per minute. The average mean blood pressure rose slightly during thoracotomy, but during occlusion of the aorta before by-pass it fell to a level of 32 to 46 mm. of mercury (average 40 mm.) in the distal aortic segment; this was only 38 per cent of the control value. During pump by-pass, however, the average mean blood pressure in the proximal vasculature was maintained at a level higher than the control. After release of the aortic clamps, the average mean blood pressure fell to control levels, and following surgery it fell slightly lower (to 93 per cent of control) at a value not

significantly different from the control level ($P > 0.05$).

Average (mean) renal blood flow decreased slightly (13 per cent) during thoracotomy and then decreased further to 3 per cent of control during aortic occlusion prior to by-pass. Mean flow returned to 117 per cent of control with the pump running, and after operation it was 111 per cent of the control value ($P > 0.05$).

Mean glomerular filtration rate fell to 62 per cent of control during thoracotomy and then to 5 per cent during aortic occlusion before by-pass. The rate increased to 58 per cent of control with the pump running and returned to 88 per cent ($P > 0.05$) following re-establishment of normal circulation after the procedure was completed.

Discussion

One of us (Moyer et al.[3]) has shown that in dogs a reduction of mean blood pressure below 30 mm. of mercury in the distal aortic segment for periods up to three hours will not produce functional renal damage. It had previously been reported that arterial pressures above 60 mm. of mercury are required for glomerular ultrafiltration.[4, 5] The data presented here suggest that maintenance of the mean arterial blood pressure perfusing the kidneys at a suboptimal level may serve a protective function, so that the glomerular filtration rate and renal blood flow can be re-established at a relatively normal level after the normal perfusion pressure has been restored. Possibly the kidneys adapt to conditions of reduced pressure in such a way that the harmful effects are minimized. They normally receive approximately 25 per cent of the cardiac output and have an arteriovenous oxygen difference of 1 to 3 volumes per cent,[6] but during conditions of suboptimal perfusion pressure and blood flow they may be able to extract a greater amount of oxygen, thus protecting against severe ischemic damage.

At any rate these studies suggest that minimal renal blood flow is needed to prevent acute renal failure. In all probability, when this phenomenon (acute renal failure) occurs, it is most often caused by a combination of factors, of which renal ischemia is only one. It would appear that toxic factors such as infection, chemicals, drugs, and incompatible blood are of primary importance in causing renal damage.

Morris and associates[7, 8] demonstrated that without any type of by-pass, a blood pressure of 12 to 30 mm. of mercury was maintained below the point of aortic occlusion by collateral circulation. In the present study, the mean blood pressures during cross-clamping of the aorta before by-pass ranged from 32 to 44 mm. of mercury, which may well have come from such a collateral circulation.

The data obtained on our patients during and after by-pass agree with the data reported by Kane.[9] An increase in mean (i.e. average) renal blood flow during by-pass was not accompanied by a proportionate increase in the mean glomerular filtration rate. After by-pass, however—that is, following completion of the procedure—the mean glomerular filtration rate approached control level while mean renal blood flow did not change significantly because the changes within the group were not consistent. In two instances it rose, in two others it fell, and in another the change was negligible.

Although the non-pulsatile pump by-pass has been reported to give, in dogs, perfusion comparable to that obtained with pulsatile flow pumps,[6, 10] changes in renal hemodynamics and autoregulatory mechanisms that are subtle and undetectable by present methods could cause differences.

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Summary

Data have been presented to show that following a period of suboptimal mean arterial blood pressure perfusing the kidneys and producing a decrease in renal function, that function can be restored, as judged by glomerular filtration rate, by restoration of normal perfusion pressure. This may be facilitated by such protective mechanisms as increased oxygen extraction during the period of suboptimal pressure and the availability of collateral circulation.

Acknowledgements

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The Depressed Patient and Physician Responsibility

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When the depressed patient comes to the attention of the doctor—because he seeks medical help or because those around him are concerned enough to call in medical assistance—a number of difficult decisions face the physician.

Is the patient able to continue to live at home? Or does he require psychiatric hospitalization?

If he is able to remain at home, does he need the kind of specialized care that will result from a referral to a psychiatrist? Or can he continue to be treated by his family doctor?

Will the so-called dynamic psychotherapeutic techniques work—can the patient secure relief by discussing his problems and ventilating his feelings, relying largely on a verbal exchange with his doctor? Will anti-depressant drugs be necessary? Will electroshock treatment be required?

If the patient refuses treatment, does the doctor have a continued responsibility to see that he gets help—or has the doctor's responsibility ended?

The treatment of the depressed patient is complicated by two factors which are frequently seen in psychiatric patients but are less common in general medical practice. The first is that the patient does not have the same ability to evaluate and to reason that he had prior to his depression and therefore he cannot always be expected to do what would seem to be in his own best interest. A doctor can recommend hospitalization but the patient may refuse the recommendation; a doctor can prescribe drugs but he cannot be sure the patient will take medication as instructed. The physician is dealing with the special problem of the rational treatment of an irrational patient, and the problem is further complicated because depressed patients may appear reasonably rational—their apparently intact facades may mask major disturbances.

But the depressed patient is often more than irrational and uncooperative; he may be actively self-destructive, and this is a second factor which complicates neat treatment programs. In addition to his lethargy and negativism, a patient may be seeking to actively sabotage his treatment. Some characteristics of the depressed patient such as poor nutrition and poor hygiene may result either from lethargy or irrationality or may represent the acting out of self-destructive concepts; other tendencies, such as misuse of medication, reckless driving, courting danger, suicidal gestures, and the ultimate danger which is suicide itself, are more obviously intended by the patient to harm himself. The physician or the hospital in charge of the patient has the unhappy choice: to try to maintain a constant vigilance over the patient in a locked-ward hospital with maximum security measures in force, which will minimize the chance of the patient hurting himself but may also minimize his chance to fight his way back to a normal attitude and way of life, or to take risks with the patient after balancing the possibility of harm against the opportunity for progress. In contrast to the psychiatric philosophy of fifty years ago when seriously depressed patients were maintained in a spartan atmosphere under constant guard for long periods of time so they would not have the chance to hurt either themselves or others, the present trend in psychiatry is only to maintain the precautions necessary to prevent harm for the shortest period which seems compatible with the patient's well being and to award the patient greater freedom and increasing privileges as he shows signs of recovery (although keeping in mind that a patient diagnosed as having a severe depression is often in greater danger of committing suicide as he starts to improve—and shakes off his lethargy—than he is when his condition is most severe). The concept that strict separation of the patient from home and family may work against his chances of recovery is now generally accepted, and phyiscians—psychiatrists and non-psychiatrists—who treat the depressed patient often operate on a theory of "calculated risk." This theory is applied not only to depressed patients but to psychiatric patients generally. The director of a psychiatric unit connected with a general hospital which will hold patients only for a maximum of six weeks before either discharging them or sending them to a hospital for chronic patients describes his service:

> Most (of the patients) are severely disturbed; some are suicidal or violent when they come in . . . About three to five days after we start treatment, the patient usually calms down enough so that visiting members of his family can take him to the coffee shop or for a walk around the grounds. . . . By gradually giving him more freedom, we're constantly testing the therapy, and we're also preparing him for discharge. And by forcing him to face his old environment, the one in which his breakdown occurred, we're able to go to work right away on the problems and feelings that come up.[1]

The extent of the problem of depression and the uncertainties that surround the problem have been well described by Beck in "Depression: Clinical, Experimental and Theoretical Aspects."[2] He states that although depression (or melancholia) has been recognized as a clinical entity for more than 2,000 years, we have no completely satisfactory explanation of its paradoxical and puzzling features, its etiology, its nature, its classification.

". . . the depressed patient is often more than irrational and uncooperative; he may be actively self-destructive, and this is a second factor which complicates neat treatment programs."

He lists four basic questions on which there is no general agreement:

1. Is depression an exaggeration of a mood experienced by the normal, or is it qualitatively as well as quantitatively different from a normal mood?

2. Is depression a well defined clinical entity with a specific etiology and a predictable onset, course, and outcome or is it a "wastebasket" category of diverse disorders?

3. Is depression a type of reaction or is it a disease?

4. Is depression caused primarily by psychological stress and conflict or is it related primarily to a biological derangement?

Since there are no clear-cut answers to these and similar questions, a doctor can justifiably treat many depressed patients in any one of a number of ways, depending on his orientation. and not be subject to criticism. The physician may recommend somatic treatment (drugs or electroshock) or he may recommend psychoanalysis or some kind of analytically oriented psychotherapy or he may recommend a change of environment (a "sea trip" or visit to a spa were recommendations which formerly were popular and still remain so with a few proponents) or he may view the process as self-limited and advise watchful waiting.

When the patient is clearly a suicidal threat, the doctor's responsibility becomes more clearcut. He will probably not be held remiss if he misdiagnoses or chooses the wrong course of treatment, but he may well be remiss if he fails to hospitalize a patient who is clearly a threat to himself. The doctor is even more clearly responsible if he heads an institution where a patient obviously requires supervision and that supervision is lacking. So when we deal with the paradoxical subject of depressions, we find that the doctor's estimation of the severity of the situation increases his degree of responsibility. If a patient not considered seriously depressed harms himself there would not be the same degree of liability as if the same harm resulted with a patient who had been considered a more serious threat to himself, who had been hospitalized, and whose hospital orders advised he be carefully watched. For example, St. Joseph Hospital in Chicago has three types of orders for suicidal patients, SP_1 requiring constant supervision and the removal of all glass and other objects with destructive potential from the patient's room, SP_2 requiring checks at fifteen-minute intervals, and SP_3 requiring only the general observation by the staff who are made aware that the patient is potentially suicidal.[3] If a patient is misclassified and is given SP_3 orders when SP_1 might be more appropriate, or if the potential for suicide is completely unrecognized and the patient is not given any of these orders, the hospital or its staff can defend themselves from charges of negligence by demonstrating that standards of medical practice consistent with those in the community were met and the unfortunate result was the product of an error in judgment—since the law recognizes that doctors are not infallible in the exercise of their clinical judgments and do not guarantee the results of their treatment. But if a written order requires constant supervision and the patient is not constantly supervised, the doctor will find it hard to defend himself in court. The doctor's evaluation of the severity of the case and the type of order he writes often determine the degree of responsibility to which he will be held.

In the absence of a showing that orders were ignored or disobeyed, courts will usually hold that a doctor is not responsible for the misadventure of his patient because he failed to anticipate irrational acts. Courts have increasingly been willing to recognize that absolute safety for a patient is incompatible with chance for progress. In the words of the Tennessee Supreme Court: "It might well be said that the use of ropes or handcuffs or other restraining forces would have retarded his natural progress in regaining his health, both physical and mental."[4]

Less frequent than suits concerning hospitalized patients are those concerning patients who it is alleged should have been hospitalized; the plaintiff attempts to hold the doctor responsible for failing to commit the patient. A recent New Jersey case concerned a patient who took his life in a jail cell. He had been arrested for an unprovoked attack on a friend, and was sent to Elizabeth General Hospital where two psychiatrists found him to be mentally ill and in need of mental hospitalization for "violent and homicidal tendencies." The patient's wife refused to sign commitment papers and he was returned to the custody of the police. Under New Jersey law, which differs from the law of most states, attending psychiatrists have authority to commit to a mental hospital any patient they feel needs further treat-

". . . a doctor can justifiably treat many depressed patients in any one of a number of ways . . ."

"Less frequent than suits concerning hospitalized patients are those concerning patients who it is alleged should have been hospitalized . . ."

The skill of following up leads and phrasing questions is of crucial importance

ment even if the family does not cooperate in the commitment. The lower court held that the wife's refusal to commit did not preclude her recovery of $35,000 damages from the psychiatrists. The Appellate Division on appeal found that the doctors were not responsible for failing to commit in the absence of family cooperation but allowed the verdict on the ground that the psychiatrists should have informed the police that the patient when transferred back to jail although calm was suffering from a dangerous mental condition with homicidal-tendencies and should have advised the police of the need to continue Thorazine.[5] The Supreme Court of New Jersey found the psychiatrists entirely without liability because the testimony of the widow's medical expert did not show a medical standard pertaining to the relationship of homicidal and suicidal tendencies, i.e., the fact that the psychiatrists had diagnosed the patient as homicidal did not require that they also envision him as having a suicidal potential.[6]

Although there have been few cases of failure to hospitalize, this in time may become a much greater source of court action than the cases dealing with care of hospitalized patients. The majority of depressed patients seen by doctors are seen by overworked and harried general practitioners who cannot give each patient an unlimited amount of time. Depressions will often go unrecognized. A physician's defense can always be that he gave to the patient the same degree of consideration and diagnostic skill as is commensurate with community standards, but if the depressed state was obvious to others the physician may seem to have been negligent in not diagnosing and in failing to advise the family of the severity of the situation. Psychiatrists are alert to cues which the general practitioner may miss, and they are more aware that the depression may manifest itself by symptoms other than changed mood or feeling. Beck lists five attributes to help us define depression, only the first of which is obviously related to mood: (1) a specific alteration in mood: sadness, loneliness, apathy; (2) a negative self-concept associated with self-reproaches and self-blame; (3) regressive and self-punitive wishes: desires to escape, hide, or die; (4) vegetative changes: anorexia, insomnia, loss of libido; and (5) changes in activity level: retardation or agitation.[7]

The physician will often be met with a denial of depression and only if he suspects the diagnosis and persists in probing a number of areas will he be certain to elicit depressive affects and thoughts. A patient who at first denies feeling depressed will often admit that at times he does feel he is worthless, that he is a burden to his family, and that he does have suicidal thoughts. The skill of the examining physician in following up leads and phrasing questions is of crucial importance here. One inventory of depressive feeling lists twenty-one categories where questions can elicit material that will help in the diagnosis. These questions involve sadness, pessimism, sense of failure, dissatisfaction, guilt, expectation of punishment, self-dislike, self-accusation, suicidal ideas, crying, irritability, social withdrawal, indecisiveness, body image changes (such as feeling old, ugly, or unattractive), work retardation, fatigability, insomnia, anorexia, weight loss, somatic preoccupation and loss of libido. The depression inventory and instructions for its administration will be found in the appendix to Beck's book.[8]

Ayd, in his book *Recognizing the Depressed Patient*, which is addressed to physicians generally, stresses that the doctor can help the patient by telling him that the illness has a physical basis, that it is self-limited, and that the patient will improve. He feels that encouragement is important and that the physician should dissuade the patient from trying what is likely to be difficult since failure only reinforces his sense of inadequacy and guilt. Ayd feels that "no advantage is gained by an intellectual understanding of the psychological aspects of the illness" although he feels it is important to pinpoint and to eliminate precipitating factors. He states that many physicians do not take cognizance of the natural course and duration of a depression and become unduly discouraged when the response is slow or the patient worsens. He believes family cooperation is important in assisting the patient to carry out medical instructions, to make environmental changes, and to fortify the patient's desire to recover.[9]

Although the variety of treatments recommended and the disagreement about diagnostic classifications help relieve the physician of legal responsibility, since good medical practice could lead to many different kinds of medical decisions, they do not relieve the physician of ethical and moral responsibility to do his best for his depressed patients. Some physicians are irritated by depressed patients and find themselves giving these patients short shrift. The care of depressed patients involve a long and careful inquiry into many aspects of his thought and life situation.

Kline has said that more human suffering has resulted from depression than from any other single disease affecting mankind.[10] Although more hospitalized psychiatric patients are diagnosed as schizophrenic than depressed, it has been estimated that outside of hospitals there are five times as many depressed patients as schizophrenic. The physician is thus dealing with a large problem. Particularly since more than 60 per cent of suicides have consulted a physician for some reason during the year preceding their act, the physician has a medical responsibility, if not always a legal responsibility, to devote time, attention, and his best efforts to the problem.

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Diazepam During Labor

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Childbirth is the most painful event in human reproduction and the degree of sensitivity to this pain varies from woman to woman.[1] The need for pain relief during this event has led to a constant and exhaustive search for an ideal drug that will relieve the pain without jeopardizing the fetus.

Diazepam, 7-chloro-1,3-dihydro-1-methyl-5-phenyl-2H-1,4-benzodiazepin-2-one, is a psychotherapeutic agent of the benzodiazepine class which has been widely used in different medical specialties. Good results have been reported with this drug in patients with anxiety[2, 4] depressions[5, 10] and other psychiatric disorders.[11, 18] Favorable results have been published on the use of this drug in the treatment of cerebral palsy patients;[19, 23] as a preanesthetic agent[24, 27] and in musculoskeletal disorders of different origins.[28, 41] This drug was also used in tetanus muscle-spasm crises, stiffness and opistotonos with good results.[42, 45] Ponce Ducharne et al.,[46] reported electroencephalographically and clinically good results in different types of epileptic patients. Bottomley et al.,[47] in a double-

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Table I

Background Data

Age Range (Years)	*Diazepam Group*	*Control Group*
10—15	26	23
16—20	240	204
21—25	183	195
26—30	85	86
31—35	40	61
36—40	18	32
40	6	2
Not reported	1	3
Total	599	606
Marital Status		
Married	374	318
Single	184	196
Widowed	1	5
Divorced	1	7
Separated	37	72
Not reported	2	8
Total	599	606
Race		
Negro	501	499
Caucasian	73	83
Other	25	20
Not reported	..	4
Total	599	606
Socioeconomic Group		
Lower	567	585
Middle	23	..
Upper	2	..
Not reported	7	21
Total	599	606
Parity		
0	220	155
1	130	130
2	78	75
3	59	92
4	29	54
5	31	31
6	18	18
7	16	19
Great multiparas (8 and more)	16	32
Not reported	2	..
Total	599	606

blind study did not find any difference in analgesic effects between aspirin and diazepam. On the other hand, Gluekman [48] proves experimentally in animals that diazepam is the most active benzodiazepine in reducing aggressive behavior, and Randall et al.,[49] proved also experimentally that diazepam is five times stronger than chlordiazepoxide as a tranquilizer and muscle relaxant and ten times stronger as an anticonvulsant drug, with both having the same tolerance.

In comparison to the other specialties, there are relatively few experiences in obstetrics and gyneecology with this drug. Cavanagh and his coworkers [50] suppressed myometrial activity in vitro by reducing the frequency and amplitude of contractions with chlordiazepoxide and diazepam, but the dose of diazepam required was five times smaller than that of chlordiazepoxide and the suppression was even more prolonged. Landesman and Wilson [51] working with uterine strips succeeded in producing complete blockage in 58 per cent of the strips from the pregnant uterus and in 12 per cent of the trials with the nonpregnant uterus with a 5μg/ml dosage of diazepam; with a 4μg/ml dose, they obtained a reduction of tonus in 91.7%, frequeney in 100% and amplitude in 91.7% of the trials.

In clinical trials, it has been used to stop premature labor,[52] as a pain-relieving drug during labor [53, 54] and in patients with dysmenorrhea.[55] Its tranquilizing myometrial effect during labor was reported by Volet and Duerey.[56] Peña [57] reports a 94 per cent result of good to excellent at the end of four weeks' treatment in ninety-nine women with gyneecologic or obstetric problems resulting from or complicated by psychoneurotic reactions.

Toulouse and Maffei [58] found that diazepam is harmless in labor, and that it has a favorable effect on the psychic state of the patients, but no analgesic effects. De Silva et al.,[59] proved that the drug crosses the placental barrier at ratios varying from 2 to 0.5 from maternal to fetal values and found a 1:1 ratio of distribution in maternal and fetal circulation with much lower levels in amniotic fluid.

Finally, Lecart and Cavanagh [60] find it disappointing as an adjunct drug in the treatment of toxemic patients. They state . . . "either that diazepam does not have a sufficient relaxant effect on the human uterus in vivo or that some other factor besides uterine tension was the problem."

This publication motivated us to try this drug on patients in labor with the intention of clarifying its effects during labor.

Material and Methods

Five hundred ninety-nine patients from Temple University Hospital were submitted to a diazepam study and 606 subsequent patients, observed under similar conditions, served as controls in this study. In both groups the management during labor and delivery were the same except for the lack of diazepam in the control group.

The diazepam was given intramuscularly in a 10 mg dose to all patients whose labor duration would permit the observation of the drug's effect upon the mother and baby for at least one hour. This dose could be repeated, if needed, for sedation if pain persisted. No restrictions on analgesic administration were made. The blood pressure and fetal heart rate were recorded at ten minutes and one hour after each dose of diazepam. The number of requests for analgesics and the patient's behavior after the drug was given (in comparison to her reactions before the drug was given) were recorded on a special chart, as well as the length of each stage of labor, type of delivery, anesthesia, postpartum blood pressure and the baby's Apgar score at birth.

Results

The background of the population in the study and control groups is tabulated in Table I. Of the study group 70.6 per cent and of the control group 65.8 per cent were in the sixteen to twenty-five year age range. Over 80 per cent were Negro. Fifty to sixty per cent of the patients were married, and practically all were in the low socioeconomic level. Of the diazepam group 36.8 per cent and of the control group 25.5 per cent were primigravid. This difference of 11.3 per cent would indicate that the two groups were not comparable in regard to length of labor and conditions of the newborn since labor is longer in primigravidas and the greater stress of labor reflects itself on the condition of the neonate.

Table II shows the concurrent sedative medication that was used in both groups. Fewer patients in the control group received meperidine than in the diazepam group. This difference could not be analyzed statistically because of the different medications received by the control group and the higher incidence of primigravida in the diazepam group.

Table II

Concurrent Sedation (°)

Type of Drug	*Diazepam Group*	*Control Group*
Demerol (Meperidine)	520	366
Demerol + Scopolamine	2	1
Scopolamine (Hyoscine)	..	1
Sodium Amytal	..	3
Nembutal (Pentobarbital)	2	6
Phenobarbital	2	6
Phenergan (Promethazine)	2	40
Reserpine	2	1
Seconal (Secobarbital)	..	1
Sparine (Promazine)	1	258
Sparine + Scopolamine	..	1
Morphine	5	4
Magnesium Sulfate	9	13
Total	545	701

(°) A given patient may appear in more than one category.

The immediate effect of the diazepam dose is shown in Table III. It is noted that all but four patients received an initial dose of 10 mg, ninety-six patients received a second dose of 10 mg and fifteen patients a third dose. It is obvious that any slight differences in mean blood pressure or fetal heart

Table III

Immediate Effect of the Diazepam Dose on the Blood Pressure and the Fetal Heart Rate

Dose Size (mg)	*1st Dose*	*2nd Dose*	*3rd Dose*
5	3	..	..
10	595	96	15
75	1	1	..
Not reported	..	502	584
Average Systolic Blood Pressure (Not Significant)			
After 10 minutes	125.2	125.1	126.7
After 1 hour	123.8	124.9	125.3
Difference	—1.3	—0.5	—2.7
Average Diastolic Blood Pressure (Not Significant)			
After 10 minutes	79.8	79.9	81.3
After 1 hour	79.5	79.4	77.4
Difference	0.1	0.9	4.4
Average Fetal Heart Rate (Not Significant)			
After 10 minutes	141.8	139.6	135.1
After 1 hour	141.4	139.9	136.7
Difference	—0.4	+0.4	+2.3

Note: Not all patients were observed at each time interval (10 minutes and 1 hour) and since differences were obtained for each patient and an average from all patients, the apparent discrepancy between the figures given is due to unequal number of patients observed.

rate between the two groups is neither statistically nor clinically significant.

On the four-point rating scale pain relief was reported as "excellent" in 4.4 per cent, "good" in 55.4 per cent, "fair" in 20.9 per cent, and poor in 19.1 per cent. Since the records in the control group did not show this rating in the majority of cases, no statistical comparison between the two groups could be carried out.

Table IV shows the duration of the three stages of labor for both groups. Both stage I and stage II labor were significantly increased in the group receiving diazepam ($P < .05$). This difference, however, is invalidated by the difference in parity.

In Table V it will be noted that the global neonatal mortality was higher in the control group than the diazepam group. This difference is not statistically significant and is probably a chance phenomenon. As can be seen by Table VI, the Apgar scores for the babies in the two groups was fairly comparable, with a slight tendency for more of the control group to show a score below eight. This is not statistically significant. There was a statistically significant difference in breathing time and time required for respirations to be well established. While this would indicate some retardation in the diazepam group, the differences clinically are not important and are easily explained on the difference in parity.

Table IV

Average Duration of Labor

	Diazepam Group	*Control Group*
1st stage—given (hours)	7.74	7.18
2nd stage—given (minutes)	43.2	34.3
3rd stage—calculated (minutes)	23.8	14.9
Total—1st plus 2nd (hours)	8.35	7.72

Comments

The patients in the diazepam group did not present any effects related to or caused by the drug, and the drug did not influence the fetal heart rate (Table III). The Apgar scores (Table VI) in both groups were practically the same, but with a tendency toward higher scores in the treated group. This suggests that, at the level at which the drug crosses the placental barrier,[59] it does not affect the baby. This is in accordance with the results obtained by Revaz et al.,[61] with microdeterminations of the fetal pH in utero.

On the other hand, the 59.8 per cent of excellent or good reactions after the drug's administration permits us to arrive at the same conclusion as Bepko et al.,[53] and Toulouse and Maffei [58] that the drug is harmless during labor, and that it has a favorable effect on the patient's psychic state. We also agree with these authors that the drug does not have analgesic effects, since the requirements for sedation were almost the same in both groups (Table II).

The statistically longer labor ($P < .05$) in the treated group (Table IV) is probably due to the greater number of primigravid patients (11.3%) (Table I) and not to the drug's capacity to stop labor, as stated by Meyberg,[52] since authors, such as Bepko et al.,[53] and Volet and Ducrey [56] did not find a difference in the duration of labor with this drug, and Lecart and Cavanagh [60] state that in vivo the drug does not have the same muscle-relaxant effect as has been found during experiments in vitro.[50, 51]

Our data permits us to conclude that injectable diazepam does not produce side effects in either the mother or the fetus, and it can be used as an adjuvant drug during labor, since it had a favorable effect on the psychic state in about 60 per cent of the patients, but the drug does not have an analgesic effect upon the labor pains.

Summary

Five hundred ninety-nine patients from Temple University Hospital were submitted to a study with diazepam during labor, and 606 patients from the same hospital and in similar conditions served as controls for the treated group.

After the drug administration, the patient's reactions were considered as excellent in 4.4 per cent; good in 55.4 per cent; fair in 20.9 per cent and poor in 19.1 per cent. No side effects were observed in the mothers or the babies. The Apgar scores in both groups were similar, but with a tendency toward higher scores in the treated group.

The duration of labor was longer in the treated group than in the control group. This difference is attributed to the higher number of primigravid patients in the treated group.

It is concluded that the drug seems to be harmless during established labor, does not stop premature labor, and has a favorable effect on the psychic state of the patient.

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Table V

Fetal Conditions After Birth

Condition at Birth	*Diazepam Group*	*Control Group*
Alive	593	601
Stillborn	9	14
Not reported	2	1
Fetal Condition After 24 Hours		
Excellent	1	..
Poor (not well)	..	2
Fair	1	31
Fine/good/well	584	532
Dead or expired	11	24
Dead or expired—2 hours after	2	..
Dead or expired—4 hours after	..	1
Dead or expired—6 hours after	1	..
Dead or expired—7 hours after	1	..
Dead or expired—19 hours after	..	1
Dead or expired—36 hours after	1	..
Dead or expired—48 hours after	1	1
Not reported	1	24

Table VI

Apgar Scoring at 5 Minutes (Not Significant)

Score	*Diazepam Group*	*Control Group*
0	9	11
1	..	1
2	11	12
3	5	9
4	8	19
5	20	11
6	25	23
7	57	43
8	111	92
9	207	184
10	151	202
Not reported	..	9
Average total score	8.24	8.29
Average breathing time (seconds)	61.0	57.3
Average crying time ($P < .05$) (seconds)	85.9	72.3
Average time for respirations to be well established ($P < .05$) (seconds)	112.2	97.4

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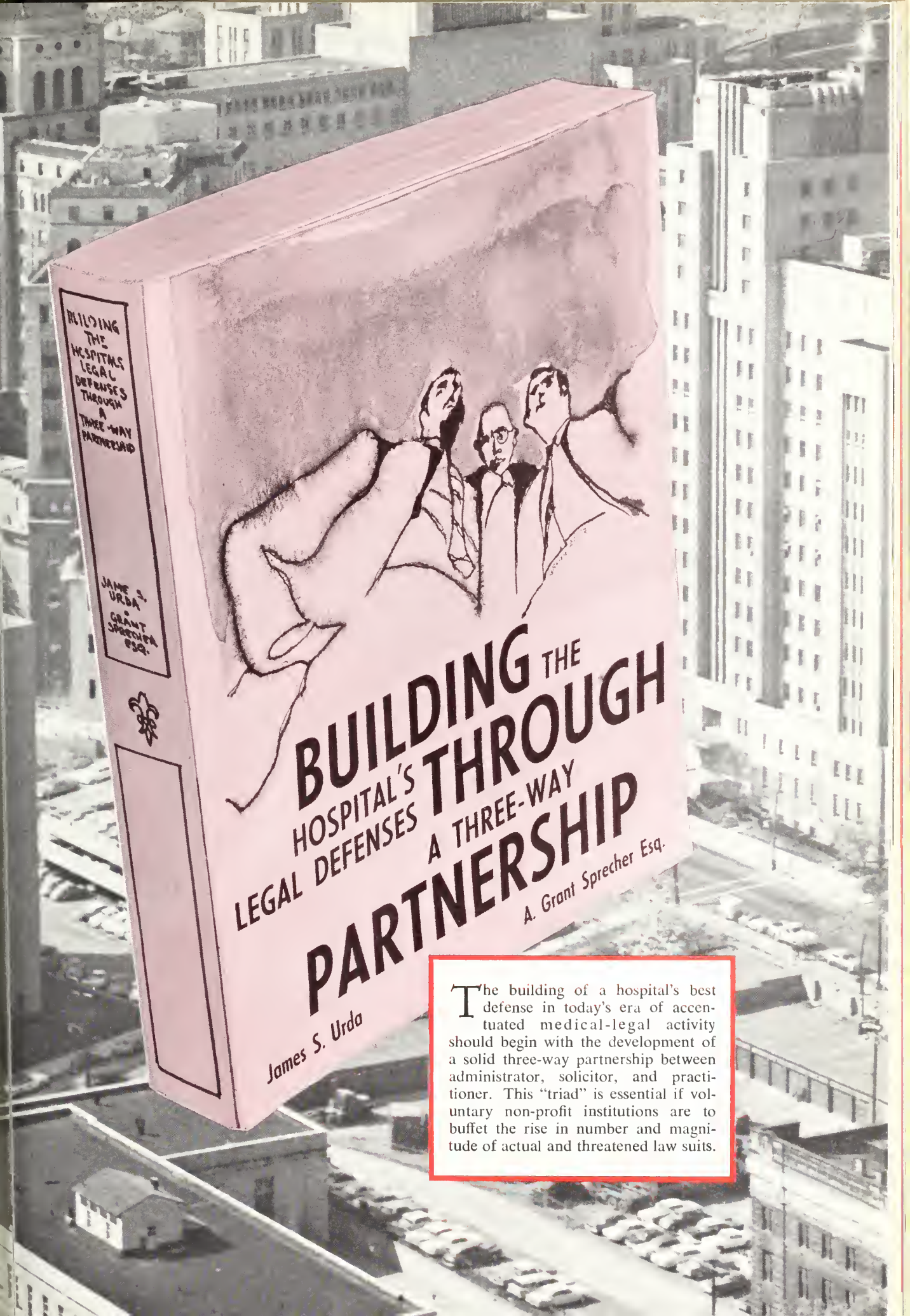

The building of a hospital's best defense in today's era of accentuated medical-legal activity should begin with the development of a solid three-way partnership between administrator, solicitor, and practitioner. This "triad" is essential if voluntary non-profit institutions are to buffet the rise in number and magnitude of actual and threatened law suits.

"I have noticed a certain natural lack of awareness among members of the medical profession as to what is significant in medical care from a legal viewpoint."

We all recognize that a jargon related to law, malpractice, and professional liability is prevalent in our everyday working vocabularies. An informed public and judiciary have served fair warning on hospitals and health care practitioners that range from popular magazine "exposes" to the revocation of the charitable immunity doctrine. Our legal accountability to the patients we serve has become crystal clear. Since charitable immunity is no longer a valid line of defense, our houses need to be put and to be kept in order. The strength of a cooperative and coordinated approach by administrator, solicitor, and practitioner can be focused to prevent unnecessary, unreasonable, and unjustified legal actions arising from patient service. It can further serve to sharpen the thrust of unified defense in any action which is presented.

A crisis in individual and institutional liability insurance support is looming. Rates in many areas have skyrocketed to the point of uninsurability in the domestic market. The trend can be moderated and reversed through implementation of a sound program of "preventive medicine" on malpractice suits. This program has been instituted with success at Jefferson Medical College Hospital in Philadelphia.

A major feature of our partnership thrust is an educational program for our staff. Every hospital practitioner —attending and house staff—is routinely exposed to discussion and review of medical-legal and professional liability matters.

We emphasize the aspect of prevention throughout our program of orientation and discussion. The following is the foundation of Jefferson's "in service legal education." It is discussed with attending and house staffs throughout the year. Incoming house officers receive a special series of lectures using "A Handbook of Preventive Medicine on Malpractice Suits for Hospital Practitioners," by A. Grant Sprecher, Esq., as a base.

Our program, in existence for a year and one half, has been tremendously successful. The following is the handbook.

Introduction

Malpractice cases against physicians and hospitals have become alarmingly commonplace in recent years. The physician who is, or has been, a defendant in a professional liability suit has an immediate reaction at the mere mention of the word "malpractice." Pennsylvania hospitals, all of which lost their immunity from suit a few years ago, have become "punching bags" for displeased patients.

This brief handbook is designed for busy practitioners as a manual of methods to prevent this unhappy proliferation of litigation and a guide to the various steps they can take to adequately defend themselves.

It should be noted that there are meritorious suits which reach the courts. When an anesthesiologist fails to note a halt in the flow of oxygen, when a nurse injects an unordered drug, when a woman's left breast is removed instead of her malignant right breast, and when a patient receives the wrong type of blood, the question is not do we settle, but how much. The patients who bring these suits and the handling of them are not the subject of this manual. Rather, the issue here is how to stop cases of no merit before they start and how to defend good medical practice if suit is instituted.

I have noticed a certain natural lack of awareness among members of the medical profession as to what is significant in medical care from a legal viewpoint. To a large degree, it is hoped this manual will fill that gap and provide you with some practical "dos and don'ts" during the treatment of potential plaintiffs. There is no intention here to discuss the law in this field in depth, but it will be touched upon where helpful to you. Finally, a note of warning: Do not use this handbook as a substitute for the necessary, detailed, legal advice from your personal attorney should the need arise. In fact, his advice should be sought more frequently than it presently is by your profession.

Who Sues His Doctor—And Why

Contrary to popular myth current among some physicians, malpractice suits are not part of a sinister conspiracy among greedy attorneys to persecute the medical profession. All too frequently, suits begin as a result of one physician making an untoward comment about the performance of another, either unintentionally or with malice. It is often something that an attending doctor states or a statement made by another physician in the subsequent chain of healers that propels the angry patient to his lawyer's door. In some cases, it is the overindulgence of a tolerant physician toward his

neurotic subject that results, at the first sign of adversity, in a lawyer's request for medical records. There are also certain persons who thirst for litigation and will sue at the drop of a swab. Doctor, beware!

Here are a few rules of thumb:

1. Avoid, if at all possible, commenting on the quality of care rendered by one of your brethren. Do not discuss a patient's clinical progress in his presence. Unguarded comments in corridors or elevators may be made in the presence of visitors or family members. In short, be discreet!

2. Do not undertake to treat a person who is obviously the litigous type or makes threatening gestures at the outset. A physician is not legally required to care for everybody who makes his way into the reception room. However, once you undertake to treat a patient, you must continue until that patient is transferred to the care of another competent practitioner. (A recent example is a dermatologist who initiated a course of treatment for a teenage boy with acne *after* the boy's mother told him that she and her husband were watching closely to see if any scars appeared on his face. This is—"asking to be sued.")

3. There is nothing to replace a good physician-patient relationship. Keep the patient advised of his progress. Lack of communication creates doubt, doubt begets suspicion, and suspicion of treatment propriety is one sure path to the courthouse.

4. If you have reason to believe that an unhappy patient might consider a malpractice suit, consult your attorney promptly and discuss with him what steps you should take in communicating with the patient or his lawyer. DO NOT WRITE LETTERS WITHOUT PRIOR APPROVAL OF COUNSEL. In addition, decide what evidence should be either retained or recorded against the day in court years later. There are too many cases tried today in which the patient swears by a set of facts, and the physician is reduced to saying: "I don't think I did that (or said that), but it has been so many years ago, etc."

5. Never discuss the care rendered to a patient with a third party unless that patient authorizes the discussion. Of course, if the conversation occurs where there is a potential malpractice suit afoot, do not consult with that person UNTIL YOU HAVE HAD LEGAL ADVICE!

Hospital Records—A Potential Hangman's Noose

Two or perhaps three years after a patient is discharged, the physician-defendant sits down with his attorney and reviews the hospital chart. All too often, this record is the only means of refreshing the doctor's recollection of treatment afforded a given person. On the basis of what is recorded rests the defense of that practitioner's performance. This defense is based not only on what the defendant recorded, but also on what was said by house officers, nurses, preparers of lab reports and his brethren in radiology, anesthesiology, etc.

I have often heard a doctor comment during the review of a chart—"That's the first time I heard that," (particularly when reading a nurse's note), or—"But he was only a medical student" (when reading a medical student's history which was not countersigned). Some physicians have stated that it was another's job to go over past hospitalizations or talk to family members about allergies. This sort of review between attorney and defendant leads to the inevitable conclusion that the physician would prefer to rewrite the chart.

It is no excuse to say that the chart wasn't written for close scrutiny by a devious, malpractice lawyer. In most instances of cases with little merit, if the chart had reflected accurately the true events of a hospitalization, there would have been no difficulty in preparing a sound and winning defense. Care in preparation of the record results in cases being dropped and verdicts in favor of physicians. Below is a list of suggestions to correct common errors.

1. Write what actually occurred or what is medically relevant. Gratuitous and irrelevant comments always cause trouble. Be precise in what you say. A comment subject to two or three interpretations by another physician opens the floodgates to a hassle over what occurred, a hassle in which the defendant physician is usually the loser.

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2. Read what others have written, particularly nurses' notes and entries by medical students. If a student's note is in error, correct it. An absence of a thorough study of past medical histories and consultation reports is inexcusable.

3. Do not alter a chart or make a correction by erasure. If you wish to amend a prior note or delete a comment, circle that note, make the correction in the margin and initial and date the correction. In addition, make a note in sequence referring back to the correction to corroborate the date of entry. This procedure will avoid the frequent charge that a physician attempted to cover up mistakes.

Is "informed consent" only required where an operation, rife with danger, is contemplated?

4. If an untoward reaction is encountered or an unexpected adverse result of surgery or treatment is met, be more specific than usual in preparing your notes. In particular, note those present, including nurses and house staff, times of arrival and times of the various medical events. Frequently, the number of minutes which elapse between problem and treatment are crucial to a defense. Who did what, when and how is essential. Vagueness in times and treatment most often works to the disadvantage of the defendant. In addition, have those present sign your notes.

5. Comments on the performance of members of the medical team in the record should be made only if medically relevant to the present and future course of treatment and you are positive of your facts prior to entry. Notes such as "called Dr. X but he refused to come," or "Dr. Y arrived two hours after paged," have no place in the chart unless the patient's progress has been affected by the absence of attention. Incident reports are the appropriate place of such comments, and physicians as well as nurses should make incident reports where called for.

6. Avoid sarcastic comments in preparing a medical record. They only inflame the passions of a jury who may be called upon to review your performance. You will be haunted by "flip" references such as, "No harm done since she wasn't too attractive to begin with."

7. Completeness is necessary. Unsaid aspects of care cause trouble three to six years later when you try to fill in the gaps from memory. In addition, the jury may not choose to rely on your recollection. However, juries tend to believe a record made commensurate with the event. This is particularly true of explanations of procedures covered later.

8. Avoid conflicting opinions in the chart if possible. You owe it to yourself and the men with whom you work to assure yourselves first that the difference of opinion is genuine. If it is, it must be recorded. However, a brief conversation with the other physician may uncover the fact that you do not disagree but that he prepared an inaccurate or poorly worded note.

9. If you look at a chart and note the absence of pages or reports, do something at once to assure the completeness of the record prior to its storage in the record room. If necessary, insert copies of the missing document or prepare a new one.

10. If you are defendant or potential defendant in a malpractice suit, make sure immediately that the raw material resulting in reports is retained. Premature disposal of x-ray films and pathology slides deprive you of a very useful weapon at trial.

11. Avoid attributing any patient problem to the acts of another physician, unless absolutely positive.

If more physicians and nurses stopped for a moment and more carefully thought out the entry they were about to commit to paper, the entire profession could be more easily defended. While many of the rules above are only common sense, it is amazing how frequently they go unobserved. I am sure that you could add to this list of eleven, and—I suggest you do so. In any event, write legibly!

Informed Consent—"Tell Them How It Is"

Informed consent is a vicious rule
Which gives our profession fits.
Must risks be explained to any old fool,
And scare him out of his wits?

How do I guess what my patient will know
When I tell him about his spine?
Later he'll cry I didn't tell him so;
T'will be just his word against mine.

Physician's Lament

Now that the law has been told off, we can pass to a practical consideration of how to meet the requirements of the doctrine of informed consent which were crystalized in Pennsylvania in the case of *Gray* v. *Grunnagle*, 423 Pa. 144 (1966).

This doctrine as announced in *Gray* may be briefly summarized:

> Unless the contemplated procedure is one of a true emergency, a physician must obtain from his patient an active consent to the procedure. This consent is valid only if the patient has a true understanding of the nature of the procedure to be performed, the alternative courses of treatment available to him and the risks inherent in each potential procedure. If the patient has not given his knowing consent to a procedure, then the physician has committed a battery upon him and is liable in damages for any adverse result.

Must every conceivable risk which appears somewhere in the literature be explained to the ill patient or his anxious family? I do not think so. The *Gray* case was unfortunately silent on this point. As I write this manual, somewhere in Pennsylvania there is a case ready for appeal which will further refine the doctrine. However, there is a New York case, *Fiorentino* v. *Wenger*, 19 N.Y. 2d 207 (1967), which indicates that only the well known risks, the ones which may be reasonably anticipated, must be explained prior to the procedure. The *Fiorentino* opinion alludes to the problem of driving a patient away from a required operation by scaring the wits out of him.

Is "informed consent" only required where an operation, rife with danger, is contemplated? I think not. The *Gray* case dealt with an exploratory laminectomy, but the reasoning of the opinion would include within its scope any procedure, operative or diagnostic, in which well recognized dangers exist. In addition, risks inherent in drug therapy would fall within the purview of its logic.

Is a signed consent form absolute protection for a physician? Clearly, the answer is no as decided by Gray. Only a consent, signed by the patient, or if incompetent, his nearest relative, after adequate discussion of the procedure will be effective evidence to back up a physician in court. Indeed, a consent signed prior to the physician's explanation is totally useless. In addition, this consent must be obtained either from the mentally competent, adult patient, the parents of a female minor or a male minor (under 21), the "emancipated female" (over 18 and married or living alone), or the nearest of kin of an incompetent.

A premedicated patient is in no condition to give consent. You should wait until the medication has worn off, then one hour more, before obtaining fresh consent.

On whom does the duty fall to obtain consent? Obviously, the physician performing the procedure in whose service the patient is admitted has the primary duty. However, he may delegate the duty of explanation to an informed assistant such as a resident. Indeed, I think the risks of anesthesia should be mentioned by the anesthesiologist on rounds. Similarly, the risk of anaphylatic shock should be covered by members of the radiology staff prior to an intravenous urogram. However, although no decisions appear on point, it would seem logical to require an attending physician to assure himself that his delegates had advised the patient of inherent risks, whether diagnostic tests or an operation are to be performed by him.

While this onerous burden of obtaining informed consent may seem an insurmountable obstacle to good medical practice, there are some vehicles available to the physician in need of self-protection which will be valuable assets in defending himself against the charge of battery:

1. When discussing a procedure with a patient, make a record of the conversation, either on office cards or the hospital chart. Make mention in the note, which should be dated and marked with the hour of discussion. of the risks explained, in general terms.

2. If at all possible, have the consent form signed and witnessed by a nurse or resident immediately after the discussion. I see only sound reasons for using the hospital operative form in your private office for this purpose. If a family member is present, by all means use that person as a witness.

3. If feasible, write a letter to your patient notifying him of an admission date and state is that letter the purpose of the admission and that risks had been explained to him.

4. The names of other physicians or perhaps a nurse, if present during the discussion of the procedure, should be noted for future reference.

5. If there is a communication problem with a patient, such as a language barrier, attempt to have a staff member present who can readily understand the patient and note his presence and assistance.

6. Check the age of a person who may be a minor but claims to have attained majority. This is particularly important when dealing with an unwed mother.

7. If you have reason to question the

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competency of a patient, seek appropriate consultation and make sure that the record reflects his opinion on soundness of mind.

8. If you have any doubts about the adequacy of consent, postpone the procedure and satisfy yourself that it is adequate. Note that the procedure has been explained not once, but twice. This extra step will be particularly helpful if treating a neurotic potential liar.

9. If for some sound medical reason the nature of the patient's true condition should be kept from him, explain the condition and the proposed treatment with a family member and have them sign the consent. Psychiatric consultation, if appropriate, is an added safeguard.

I have attempted to cover some of the usual problems and solutions. However, there are as many variations as there are hospital beds, and the hospital administrator should be consulted if a particularly bothersome variation pops up. By now, you are probably cursing the prospective volume of paper work and time which will be consumed in careful "consent" procedures. However, it is essential to use extra care in this area. Lack of informed consent is the easy road to quick recovery for an unhappy patient since he need not prove that you were negligent to find his pot of gold at the end of the litigation rainbow.

Recurrent Problems

One who handles a substantial volume of malpractice litigation in the defense of physicians and hospitals and reviews hospital incident reports regularly soon learns that there are recurring charges of negligent treatment, some of which are often meritorious. Discussed below are several of these problems and the significance of each to the legal profession. Left to you are the solutions and corrections, if any, available within the limits of hospital resources.

Restraints—"After the Fall"

In reviewing incident reports, the most frequently encountered mishap involves the use of restraints, or primarily the lack thereof. Some descents over the top of bedrails would do credit to an Olympic diver. Falls from beds are commonplace. Less likely is damage done to a patient from being too tightly bound. Both problems occur particularly during the nursing shift of 11:00 p.m. to 7:00 a.m. True, most of these accidents happen as a result of changes in patient condition—both unanticipated and sudden. Nonetheless, many mishaps cannot be explained, and additional attentiveness is in order.

- House staff officers on duty at night must respond to the calls from nurses to examine a patient and order additional restraints which only a physician can order. A lawyer looks for the length of time which elapses between the time that restraints are needed (usually the first notation in nurses' notes of undue patient agitation), and the time that restraints are ordered, if ever. I have discovered that the vast majority of nurses on duty at night call for physician help only if genuinely necessary.

- Do notes in the chart, both progress notes and nurses' notes, give an indication that more or less restraints are suggested? If they do and none have been either ordered or withdrawn respectively, there may be a meritorious claim. A doctor is on his mettle to explain why a continually agitated patient is permitted to sleep with no restraints at all or a patient who has been calm for days was injured by apparently unneeded restraints. Of course, physicians can readily explain most of the problems, but juries are quick to hold doctor and hospital liable if such explanation flies in the face of common sense.

- Why wasn't a change in restraints suggested? This problem relates most frequently to a lack of attention to nurses' notes and communication with the nursing staff, the only perpetual observer of patients. Why does the M.D. not know what the nurse has observed? This is the question most often asked by the lawyer—and perhaps later a judge and jury!

Understaffing—
"Where were you when I called?"

All of us are aware of the problems of less than the most desirable coverage and the reasons for it. Assuming less than an abundance of nurses and housestaff, is there not something that can be done to minimize the problem? Understaffing is the easiest allegation of negligence that can be leveled in court by an unhappy patient; not understaffing generally, but a lack of adequate staffing in relation to a given patient on a given floor during a single hospital admission. Affirmative answers to the following questions provide necessary ammunition for the defense arsenal.

1. Was the patient seen by both nurses and house staff as frequently as he would have been in any other institution in the community?

2. Does the fact that a patient missed his 4:00 p.m. medication relate solely to a major emergency elsewhere which occupied an unexpected number of persons who would have

otherwise have been available to give the medication?

3. Was the nurse's aide able to recognize the need for additional observation and action by the R.N. or an intern?

4. Did the resident use sound judgment in not calling and waking the attending physician?

5. Was there no need to seek additional staff help when the attending physician was called and found unavailable?

6. Is there a rational explanation for a fifteen-minute delay on the arrival of the resuscitation team?

7. Was there no need to attend the critically ill cardiac patient while he lay on a stretcher in the corridor outside an x-ray room for an hour waiting for an angiogram?

There are an infinite number of questions which could be asked in the same vein. If the answers to these questions is "no," a lawyer will favorably consider suit—and sue everyone in sight!

Medications—"Isn't that Pink Pill Larger than the Last White One?"

Missed medications and a change in medication unexplained to a patient cause immediate apprehension. The need to use a drug to which a patient may be allergic must be explained. In addition, over or under dosages are problems. A few simple steps, too frequently ignored, could easily assist in the prevention of suit.

1. If a medication is missed, the physician should reassure the patient that no harm has been done. Do not leave these explanations to a nurse, particularly not to the nurse responsible for missing the dosage.

2. A carefully worded progress note reflecting the need for new medication, the reasons for less or more medication, the effect of an overdosage, the effect of an unordered drug on the patient, and the reasons for giving a potentially dangerous drug cannot be emphasized enough.

3. Once again, an incident report is the appropriate vehicle for commenting on the reasons for failure to carry out orders as directed.

4. Oral orders, in particular those given over the telephone, should be avoided. Most inaccurate dosages seem to result from either a misunderstanding of what the physician said or a change in order between the time the nurse listened to the order and when she recorded it. There is no excuse for a house officer to give a telephone order only because it is inconvenient for him to go from one area of the hospital to another. Of course, lack of legibility is a prime problem too.

5. Unauthorized personnel giving medications can be clear liability. An intravenous injection given by a nurse whom the hospital has not qualified for this type of administration is a prime example.

Patient Identification—"Whose Leg Was That"

It seems extraordinary that today patients still receive the wrong operation, drug or treatment due to a lack of proper identification. When this happens, often no harm has been done and, if so, a patient should be promptly told so by his attending physician. (A recent event in a hospital, which will go nameless, is illustrative. A patient was sent to the O.R. for removal of teeth. After the administration of anesthesia, this patient was mistaken for another and had performed a textbook perfect cystoscopic procedure. No lasting harm done. While still on the table, the mistake was discovered and his teeth were removed. I believe his dentist told him he had long roots.)

1. It is worth mentioning here that good public relations often save the day, and prompt handling of this type claim can save money, time and worry in the long run.

2. Blame for mistakes in identity should not be spread across the chart.

3. Must the patient be told that he ingested his roommates aspirin and not his ordered penicillin? If there has been an adverse effect on the patient, he or his family must be told at some point in time, and a correct record must be written. Otherwise, sound analysis of the patient's condition and character, and the effect of this information on him, is the rule. Resolve all doubts in favor of divulging the information.

Summary

In this brief handbook, I have attempted to discuss difficulties which are most often involved in litigation and have tried to answer some of the questions most frequently posed by physicians. There are literally hundreds of appropriate medico-legal topics which could not be mentioned here. It is suggested that you resort to sound expertise whenever necessary.

Physicians are easily discouraged when they find themselves a defendant in a malpractice case. You need not be. Of all the types of cases in the personal injury field, the malpractice case still remains one of the most successfully defended. Greater awareness of the problem and greater care in the handling of both patients and records are the first line of defense. Only your efforts can stem the tide.

Mr. Urda is associate director of Thomas Jefferson University Hospital and has the degree of Master of Hospital Administration. Mr. Sprecher, an attorney, received his law degree from the University of Pennsylvania, and is secretary and solicitor for Thomas Jefferson University. He has represented physicians, nurses and numerous hospitals in malpractice litigation.

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Wasted X-Rays

JOHN L. McCLENAHAN, M.D.
Philadelphia

The debate continues about the dangers of medieal radiation, and no elear deeision seems in prospeet. Dr. Karl Z. Morgan, of Oak Ridge, Tenn., and Mr. Ralph Nader, of *The Ladies Home Journal*, gloomily report that in Ameriea eaeh year thousands of new caneers and eases of leukemia ean be traeed to diagnostic x-ray machines, at an annual cost in lives of between 3,500 and 29,000. Respected spokesmen for the radiologieal establishment brand sueh statements rabble-rousing nonsense. They assure us that we have nothing at all to fear from x-rays as long as we eontinue to irradiate eaeh other intelligently and with safe apparatus. Who are we to believe?

In this eontroversy the argument on each side is pat, predietable and euriously free of a single adjeetive that could, if given the emphasis it deserves, soon reeoncile every differenee and restore to the public the peace of mind it so eagerly desires. The word is *necessary*. Dr. Morgan has not yet suggested that we dispense with *all* medieal radiation and return to the diagnostic approaches of Hippocrates and Auenbrugger. He coneedes that some examinations contribute to the relief of pain and the saving of life. Radiologists, for their part, have not yet laid aside the first maxim of their trade: all unnecessary exposure of a living thing to x-rays is to be condemned. It seems to follow that what everyone wants is for doetors to exercise as much restraint as possible in the use of x-rays for diagnosis. This is a reasonable objeetive, and for many years there has been talk of the need for restraint in journals of radiology and at learned eonvoeations. It is equally true that anyone today who stands beside an x-ray maehine in a busy clinie will reaeh the following conclusions within an hour:

1. It is easier to order an x-ray examination than to think. This is partieularly true in large teaching institutions with researeh eommitments.

2. X-ray examinations are regularly performed when an accurate diagnosis can be made with the naked eye, ear or finger. This exereise is ealled "ruling out."

3. There are heavy legal penalties for anyone who fails to order an x-ray examination, no matter how trifling the injury or illness in dispute. There are no penalties at all for frivolous or repetitious radiography.

4. Almost everyone is covered by some sort of insuranee that will pay the eost of x-rays, whieh means that expense is no longer a deterrent.

5. More films per examination are now needed to make a diagnosis than formerly, even though technieal improvements have redueed the amount of patient exposure per film.

6. There is a shortage of trained workers. Demands for x-ray service are increasing in the face of a dwindling number of radiologists and technologists, a trend that will lead to hasty, hazardous technique.

7. Folkways and other traditional rites, of doubtful rationality, lead to more unnecessary exposure of patients and needless waste than most of us suspect.

Proliferation of teehnology, for example, masquerading as research. This camel entered our tent after World War II and has led a charmed life ever sinee, immune to skeptieism or cost accounting. It encroaches on the direct, thrifty, self-involving practice of medicine. Sometimes it is fantastically ingenious, sometimes it is merely silly. It is nourished by governmeni grants, which wells are beginning to dry up, and by the mystique of serendipity that maintains that there is no such thing as waste beeause something of value may come out of the most unpromising material. In the journals on our desks we read, with wonder, accounts of more complieated ways of deriving more speeifie information. But we seareh in vain for any report of a series of patients analyzed in terms of the eost of specifieity or its eventual eontribution to the recovery of a sick man. A surgeon in a modern Ameriean hospital can approaeh a cyst of the tail of the panereas with rabbinical precision. Angiography and isotope scanning make it possible, but while he operates the rest of the world stands by with its small, uneounted disasters—hernias, eataraets, toothache, tuberculosis, fistulas, eleft palates—that await mere cure.

Radiologists spend a great deal of time repeating examinations. They spend a great deal of time wondering why. Frequently an examination is repeated to confirm an uncertain observation or to determine whether or not a lesion has ehanged. But there are other, more extravagant reasons. People in the bloom of health are referred every April for a G.I. series because they onee had an ulcer. Uneomplaining they gag down a cup of barium because someone's doetor or someone's wife feels that "it's always better to take x-rays and be sure." In waiting rooms they sit beside erstwhile eonsumptives whose lungs healed in ehildhood, but who still appear for a film or two every six, twelve or eighteen months. As they grow old their normaley is eonfirmed, and everyone breathes easier.

It should eome to doctors as no surprise to learn that the indieations for an x-ray reexamination are often geographic. Some interns and some chiefs reorder, by reflex, a series of x-ray examinations when a patient enters their hospital even though he may carry in his hands a set of films one week old that establish his diagnosis unequivocally. This is tiresome and expensive, but patients seldom complain. Some of them even seem to enjoy the aura of the academy.

X-rays are commonly used to treat anxiety in patients or in doctors. A young man, aged 13, with a eongenital anomaly of the lumbar spine was subjected, in three years, to more than 76 exposures of the lumbar spine, almost all of which included the gonads. His clinieal eourse was serene. His life was not in danger. But his surgeon was worried about the viability of a fusion, and only pietures could reassure him. The photon poultiee has become a standard instrument of psychotherapy for neurotie women with low pain thresholds. It is remarkable how many thick film envelopes in our

files carry the names of troubled people with bizarre digestive complaints, weird pain, poorly authenticated injury and erratic skeletal distress. It is a minor irony of medicine that radiologists, who see so many manifestations of functional disease, so seldom think or write about it. In the cellar of one practitioner are many films illustrating the normal anatomy of a hard, beautiful, vindictive, full-bosomed, self-centered divorcee who stole another woman's husband, lost him out of jealousy and spent the next year consulting orthopedists and radiologists about the chronic pain in her back, sacrum and pelvis that she was convinced had made it impossible for her to keep her marriage alive.

Perhaps the word "routine" brings radiologists more business than any other—not all of it necessary business. Healthy, young primigravidas because their obstetricians "require pelvimetry as a routine for every patient during her first pregnancy." Fat ladies, with gallbladders crowded with stones and chronic indigestion, report for barium enemas, G.I. series and excretory urograms because this is "a routine precaution" and their doctors "do not want to overlook any other contributing factors to their trouble." When does the radiologist stop looking?

Many examinations are routine because lawyers and insurance companies demand that they be done, principally to establish an anatomical baseline. X-ray examinations by the thousands are made of injuries—however minor—of the neck with very little to show, for the most part, but a few small bone spurs that have been there for years. Many x-ray examinations are made to establish whether or not a pathognomonic sign is really a pathognomonic sign—local tenderness in acute subdeltoid bursitis, Osgood-Schlatter's Disease and avulsion injury of the Achilles tendon. In these circumstances radiography may rule out the remote differential possibility of gout or metastatic tumor but, as a practical matter, it contributes nothing to the care of the patient.

Many "survey examinations" are done of colons, chests and breasts of asymptomatic patients in order to uncover unsuspected disease. Mammography, one of the most expensive and time-consuming, is still being evaluated and may or may not prove to be practical for masses of people. For the rest, a great deal of money and radiation are spent uncovering a single patient with tuberculosis whose tuberculin test is negative, one patient with a malignant polyp of the colon that is not bleeding and one patient with carcinoma of the stomach that is not causing symptoms. The results of semi-annual chest screening to discover resectable lung cancers have been ruled "discouraging."[1] The whole concept of periodic examination of healthy subjects has been aptly summed up in *Lancet*[2] by Dr. Asher:

> "One of the most irrational and comforting delusions held by the layman is the notion that his body is really a kind of a motor-car. 'I feel much better now you've given me a thorough overhaul' is a remark I have heard on many occasions. Doctors are often guilty of nourishing this delusion when they make remarks such as 'You'd better come in for a complete checkup.' Behind all this lies the delusion that the physician is likely to remedy defects as he finds them—applying a little oil here, fitting a replacement there, and possibly clearing out a blocked pipe. Businessmen and high-up executives like to have complete check-ups at regular intervals . . . this emphasizes their importance and also it gives them a feeling of security, as they come out of the clinic rejuvenated by a comforting illusion of physical decarbonization. But the analogy with the motor-car engines is false, and the only point where it applies is when the trouble is very serious the patient is likely to be returned to his Maker."

The arithmetic of radiology today is interesting and not very complicated.

Dr. McClenahan is a diplomate of the National Board of Medical Examiners and a fellow of the American College of Radiology.

Between 1958 and 1963 the population of the United States rose from approximately 174 million to approximately 189 million—a calculated net growth rate of 14.3 per cent.

During the same period the amount of x-ray film shipped in America—a fair indication of the amount used—rose from 218 million square feet to 313 million. This is an increase of not quite 44 per cent.

Population up 14.3 per cent; film consumption up 44 per cent.

In 1966 there were about 8,000 practicing radiologists in America. The anticipated need for radiologists in 1975 is between 20,000 and 25,000. With a net annual increase of 200 trained radiologists per year this goal cannot possibly be met unless standards for certification are thrown out the window. The present tendency is to make standards more rigid and the period of training longer.

When supply and demand are considered in these terms it seems clear that the only way diagnostic radiology can be kept safe and efficient is for doctors to assume reasonable control of demand. To remember restraint. To forget the word "routine." To ask themselves, when they reach for an x-ray requisition form, whether the results of the examination are going to influence their management of their patient one iota. And if not, to throw away the paper.

The final responsibility for wasted x-rays lies with radiologists. They do well to come down on the beam, inspect their machines, eliminate fluoroscopes from shoe parlors and carry on research on radiation hygiene. In the end the only control lies in the finger on the switch and on the willingness of a few people, sometimes, to refuse to push the button. Radiology is now seventy years old. It has, we are told, come of age. It should be possible, by now, to decide with accuracy when it should be used, and to eliminate senseless repetition and interminable follow-up examinations. It should be possible to spend less time with computers and insurance administrators discussing the high cost of x-ray waste. And by doing better the work that must be done, and doing less of the work that never need be done at all, to meet the deadline of 1975 safely and economically.

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2. **Asher, R.:** Talking Sense, *Lancet, 2:* 418 (Sept. 26) 1959.

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Indication—Oral contraceptian.

Contraindications—Thrambaphlebitis, thrambaembalic disarders, cerebral apaplexy or o past history af these conditians, markedly impaired liver functian, knawn ar suspected carcinoma of the breast, knawn ar suspected estragen-dependent neaplasia, undiagnased abnormal genital bleeding.

Warnings—Watch far the earliest manifestatians of thrambotic disarders (thrambophlebitis, cerebrovascular disorders, pulmanary embalism, retinal thrombasis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in martality and morbidity due ta thrambaembalic diseases in wamen taking oral cantraceptives. In these cantrolled retraspective studies, invalving 36 reparted deaths and 58 hospitalizations due to "idiapathic" thrambaembalism, statistical evaluation indicated that the differences observed between users and nan-users were highly significant. The canclusians reached in the studies are summarized in the table belaw:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No camparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannat be applied directly ta wamen in other cauntries in which the incidences af spontaneously occurring thrombaembalic disease may differ.

Discontinue medicatian pending examinatian if there is sudden partial ar camplete lass of visian, or sudden onset of praptosis, diplopio ar migraine. Withdraw medicatian if papilledema or retinal vascular lesians are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled aut for any patient who has missed two cansecutive periods before continuing the cantraceptive regimen. If the patient has nat adhered to the prescribed schedule the passibility of pregnancy shauld be considered at the first missed period.

A small fractian of the harmone agents in oral cantraceptives has been identified in the milk af mathers receiving these drugs. The lang-range effect an the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examinatian shauld include special reference ta the breasts and pelvic argans, and a Papanicolaau smear.

Endacrine and passibly liver functian tests may be affected by Ovulen. Therefare, it is recammended that such tests if abnarmal be repeated after the drug has been withdrawn far twa manths.

Pre-existing uterine fibramyamas may increase in size under the influence af pragestagen-estragen preparatians.

Because these agents may cause same degree af fluid retentian, canditians which might be influenced by this factar, such as epilepsy, migraine, asthma, cardiac ar renal dysfunctian, require careful abservatian.

In breakthraugh bleeding, and all irregular vaginal bleeding, cansider nanfunctianal causes. Adequate diagnastic measures are indicated in undiagnased vaginal bleeding.

Carefully abserve patients with a histary af psychic depression and discantinue the drug if severe depressian recurs.

Any passible influence af pralanged Ovulen therapy an pituitary, avarian, adrenal, hepatic ar uterine functian awaits further study.

A decrease in glucase talerance has accurred in a significant percentage af patients an aral cantraceptives. The mechanism af this decrease is abscure. Far this reasan, diabetic patients shauld be abserved carefully while receiving Ovulen.

Because af the effects af estragens an epiphyseal clasure Ovulen shauld be used judiciausly in yaung patients in wham bane grawth is nat camplete.

The age af the patient constitutes na absolute limiting factar, althaugh Ovulen therapy may mask the anset af the climacteric.

The pathalogist should be infarmed af Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant assaciatian has been shawn between use of oral cantraceptives and the fallowing seriaus adverse reactions: thrambophlebitis, pulmanary embolism.

Although available evidence is suggestive of an assaciation, such a relatianship has been neither canfirmed nar refuted far the fallowing serious adverse reactions: cerebrovascular accidents, neura-acular lesians, e.g., retinal thrambasis and optic neuritis.

The fallawing adverse reactians are known to occur in patients receiving oral cantraceptives: nausea, vomiting, gastrointestinal symptams (such as abdaminal cramps and bloating), breakthrough bleeding, spatting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma ar melasma, breast changes (tenderness, enlargement, secretian), change in weight, changes in cervical erosian and cervical secretions, suppressian af lactatian when given immediately past partum, chalestatic jaundice, migraine, allergic rash, rise in blaad pressure in susceptible individuals, mental depression.

Althaugh the fallawing adverse reactians have been reported in users af aral cantraceptives, an association has been neither canfirmed nar refuted: anavulation past treatment, premenstrual-like syndrome, changes in libida, changes in appetite, cystitis-like syndrame, headache, nervousness, dizziness, fatigue, backache, hirsutism, lass af scalp hair, erythema multifarme and nadasum, hemarrhagic eruptian, itching. The fallawing laboratory results may be altered by aral contraceptives: hepatic function: increased sulfabramophthalein and ather tests; caagulation tests: increase in prothrambin, Factors VII, VIII, IX and X; thyraid functian: increase in PBI and butanal extractable pratein baund iodine, and decrease in T^3 uptake values; metyrapane test; pregnanedial determinatian.

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1969 Pennsylvania Wheelchair Games

"Remember . . .
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This is the motto which sets the tone for a unique event in the Commonwealth—The Pennsylvania Wheelchair Games.

Humble beginnings just two years ago have led to state-wide prestige and area-wide participation in an athletic exhibition which brings wonder to the eye of the beholder, fierce competition into the heart of the participant, and a sense of satisfaction to physicians, especially specialists in the field of orthopedics, who know the value of physical activity for the physically handicapped.

Although the Pennsylvania games are relatively new the need for recreation and sporting activities for the disabled was recognized immediately after World War II. Basketball played from a wheelchair was the beginning of wheelchair sports in the United States. In England, at the Stoke-Mandeville Spinal Injuries Center, other sports were adapted for play from a wheelchair—javelin throwing, shotput, table tennis, archery. Swimming also was encouraged as a sport for the physically handicapped.

Willard H. Love, Jr., M.D., *Harrisburg, vice-president of the Pennsylvania Orthopaedic Society, at right in the above picture, presents a trophy to the coach of the winning team in the 1969 games. Winners were the Central Penn Wheelers, coached by Lou Neishloss, above, left.*

The first wheelchair racing event ever held anywhere was part of the track and field events for the physically handicapped held in the United States in 1957 under the sponsorship of the Joseph Bulova School of Watchmaking, Jackson Heights, N.Y., which has sponsored every subsequent national meet since then. Ten states held regional meets in 1969.

Although the Pennsylvania games have been held just twice, the weekend event draws athletes from throughout the northeastern part of the country, and winners of the events have made Pennsylvania a name with which to be reckoned in the national meet, and this year in the International Games in London, which were held in July, and the Pan-American Wheelchair Games which are scheduled for Buenos Aires, Argentina, in December.

Moreover, the Pennsylvania Wheelchair Athletic Association, just a year

old, is the first state association to be recognized officially by the National Wheelchair Athletic Association. When the first Pennsylvania games were held, informal groups which met for exercise and recreation, as well as therapy, participated. They included the Central Penn Wheelers, Easter Seal Paranauts, Keystone Spokes and Johnstown Wheelchair Athletic Association. The moving force behind the first wheelchair games held here, and the man responsible for the birth of the Pennsylvania Wheelchair Athletic Association, is H. Charles Ryder, principal of Highland Elementary School, Camp Hill, who helped to organize and officiate at the first National Wheelchair Games, held at Adelphi College, Garden City, N.Y. Cooperation of civic organizations and donations from businesses and interested citizens including a number of doctors help to defray the expenses of the annual week-end meet, which attracted more than 100 participants to Camp Hill last May. Officials and coaches, as well as other assistants, are recruited from the area, and include many who coach school athletics in the area.

Events featured in the 1969 Pennsylvania Wheelchair Games included javelin, discus, shotput, wheelchair slalom, 60 and 100 yard dashes in wheelchairs, swimming, archery, table tennis and weightlifting.

Pennsylvania was represented at the International Games in London in July by several team members and an official, Jack Dello Iacono, Camp Hill,

Tri-County YMCA swimming coach, who helped to coach the U. S. Swim team. Rosalie Hixson, member of the executive committee of the Pennsylvania Wheelchair Athletic Association, won four gold medals at the London meet. Joan Russell, also representing the keystone state, brought home a gold medal and other awards. The U. S. team also participated in an exhibition of wheelchair sports skills in Vienna, Austria, following the London games.

Mr. Ryder has been asked to accompany the seventy U. S. athletes who will participate in the Pan American Games in Buenos Aires in December.

The 1970 games of the Pennsylvania Wheelchair Association tentatively are scheduled for Camp Hill, and the association is looking forward to 1971, when the National Wheelchair Games may, in a precedent-breaking move, bring the event into the Commonwealth. Since the inception, the national games have been held either in Garden City or Jackson Heights, N.Y.

With a national accent on physical fitness for all, those who know what it is to overcome physical handicap to achieve it are an inspiration. At the banquet held at the close of the 1969 Pennsylvania Wheelchair Games, Winners received awards from Willard H. Love, Jr., M.D., president-elect of the Pennsylvania Orthopedic Society, but in reality every participant was a winner in a victory over physical disability.

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Policy Statement On

Organ Transplantation

Of The Pennsylvania Medical Society

"The interests of the Pennsylvania Medical Society in the transplantation of organs from one human to another or from a lower specie to man is a valid one, and the membership should be completely advised of the current state of the art, and the availability of such services for either prospective donors or recipients. This will enable members to properly advise their patients.

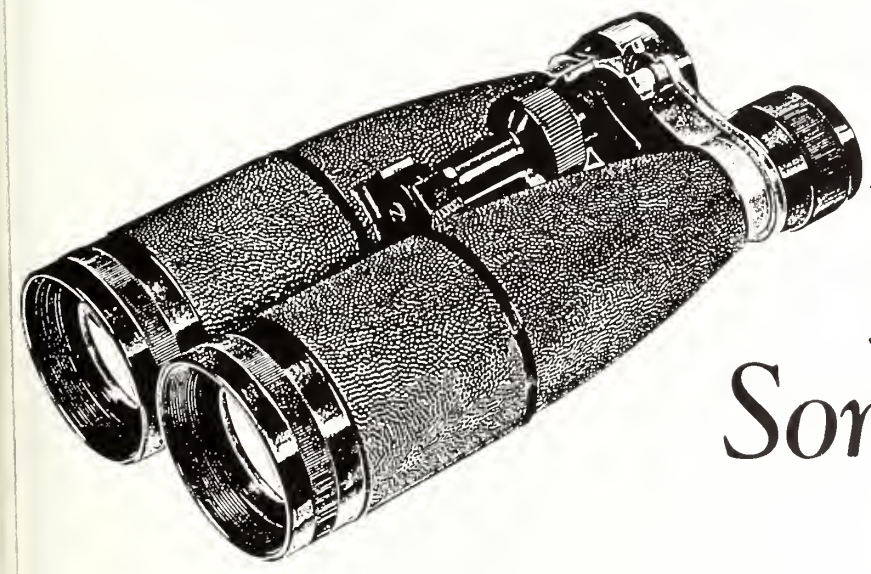
"The attitude of the Society must reflect the scientific community's viewpoints, and coincide with guidelines promulgated by the AMA. For procedures where immunosuppression is not needed, appropriate specialty boards and appropriate specialty societies govern the practice. Here the Society can contribute by pointing out where potential recipients or donors might be referred.

"On the other hand, the Society feels an obligation to suggest to its membership, through the medium of the Council on Education and Science,

a. that the transplantation of organs should be performed only in such institutions which have on their staff the scientific potential and equipment to assume all of the obligations of such an activity,

b. that there be available to such teams, experts in the field of immunology as well as specialists in the field of the organs which are to be transplanted; i.e., nephrologists where renal transplants are to be undertaken, cardiac catheter specialists and cardioradiologists where heart transplants are to be undertaken, etc.,

c. that there be sufficient support equipment available such as extra-corporeal circulation or renal dialysis equipment with experienced technical help to employ and maintain this equipment, as well as sufficient backup equipment to prevent hazard from equipment failure."



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Treatment of Arrhythmias Complicating Acute Myocardial Infarction in the Coronary Care Unit

Part II

Irving Imber, M.D., senior physician, Reading Hospital, Reading, is questioned by William G. Leaman, Jr., M.D.

Since ventricular premature beats are commonly noted in acute myocardial infarction, what is the treatment of choice?

Lidocaine has been established as the initial drug of choice in controlling acute ectopic ventricular arrhythmias. It may be given intravenously (25-50 mg.) followed by a maintenance continuous I.V. drip. The rate of the drip is determined by the suppression of the premature ventricular contractions. If the dosage of lidocaine (xylocaine) required to suppress the ectopic beats is greater than 5 mg. per minute, procaine amide or quinidine should be added. The usual dose of procaine amide is 500 mg. every four to six hours. If quinidine sulphate is used, 200 to 400 mg. every four to six hours is recommended. The latter in combination with lidocaine has been found to be uniquely effective. If digitalis toxicity is suspected propanolol (Inderal) the only presently approved beta adrenergic blocking drug, may prove effective when the above agents have failed. The dosage is 1 mg. by slow intravenous drip, followed by 10 to 20 mg. four times daily.

Why is control of ventricular premature beats so critical?

Ventricular premature beats are often the forerunners of ventricular tachycardia or fibrillation. If the patient develops ventricular tachycardia with circulatory collapse, 100 mg. of lidocaine should be given intravenously. If there is no effect or if vascular collapse occurs, precordial shock must be given by a defibrillator within 30 to 60 seconds. The treatment of ventricular fibrillation is instant defibrillation as above since it is the only reliable way of terminating this otherwise fatal arrhythmia. Direct current cardioversion is preferred.

How should supraventricular arrhythmias be managed?

Atrial arrhythmias are often transient. In this case, they do not require treatment. If they persist, however, attempts to convert to sinus rhythm should be made to avoid serious arrhythmias. Atrial and nodal premature beats should be treated with cautious digitalization and/or quinidine. Paroxysmal atrial or nodal tachycardia should be treated first by carotid sinus massage, then by digitalis if conversion is not accomplished. Cardioversion should be used if vascular collapse is imminent. Atrial fibrillation is often controlled by digitalization resulting in reversion to sinus rhythm. Cardioversion has been used with success, especially if the ventricular rate is not controlled by digitalis. Atrial flutter should be treated by cardioversion since this method is uniformly successful. Sinus tachycardia is a normal circulatory response to many stimuli. If it persists in infarction, other complications should be searched for and treated. The nodal rhythms are essentially comparable to the similar atrial arrhythmias in the matter of treatment. Persistent nodal tachycardia is often evidence of excessive vagal tone and atropine may block this.

Will you discuss the management of the bradyarrhythmias and atrioventricular block?

Sinus bradycardia may occur as the result of damage to the S-A node or atrium or increased vagal tone. If the rate does not fall under 50 and premature ventricular contractions, failure and hypotension are absent, no therapy is necessary. If the rate falls under 50, atropine, 0.6 to 1.0 mg. is given intravenously. If premature ventricular contractions occur, isoproterenol (1-2 mg. in 500 cc. dextrose) is added. Electrical pacing is rarely necessary. First degree heart block is common. In high degrees of A-V block, intravenous atropine is used. Second degree A-V block requires immediate treatment with atropine. If no response occurs, isoproterenol is used. A pacing electrode should be inserted into the right ventricle of all patients who do not respond to these measures. This pacemaker should be of the "demand" type. Third degree heart block is usually associated with a high mortality. Pacemaker implantation is the treatment of choice since drug therapy is usually transient. When both second and third degree block occur, a large intravenous dose of cortisone derivative may be helpful in restoring normal rhythm.

What has been the experience of the coronary care unit at the Reading Hospital?

There has been a definite decrease in the mortality rate (24 to 14 per cent). This decrease has been the result of effective use of drug and electrical treatment of the potentially dangerous and fatal arrhythmias. The unit consists of eight leads, and patients with proved myocardial infarction remain approximately five days. The majority of the patients are managed by qualified internists and cardiologists. General practitioners may manage their own patients, but they are required to ask for assistance by a coronary care committee or cardiologist. The coronary care nurses are the backbone of the unit. They are trained by staff physicians by means of lectures and on-the-job training. In addition, twice weekly teaching sessions are held by the coronary care physicians to review and discuss cases and electrocardiograms.

■ **William G. Leaman, Jr., M.D. edited this brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.**

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Reach To Recovery Program — Part II

This month's Cancer Forum continues our explanation of the American Cancer Society Reach to Recovery Program.

When the mastectomy patient is told by her physician that she is ready to be fitted with a regular prosthesis, she may visit the society's unit in her local area, or the Reach to Recovery volunteer coordinator assigned to her, for further information on the various types of forms available and where they may be purchased. Patients are also given assistance on special clothing problems. Nothing is ever sold to a patient, no products are ever sponsored, and patient names are kept confidential.

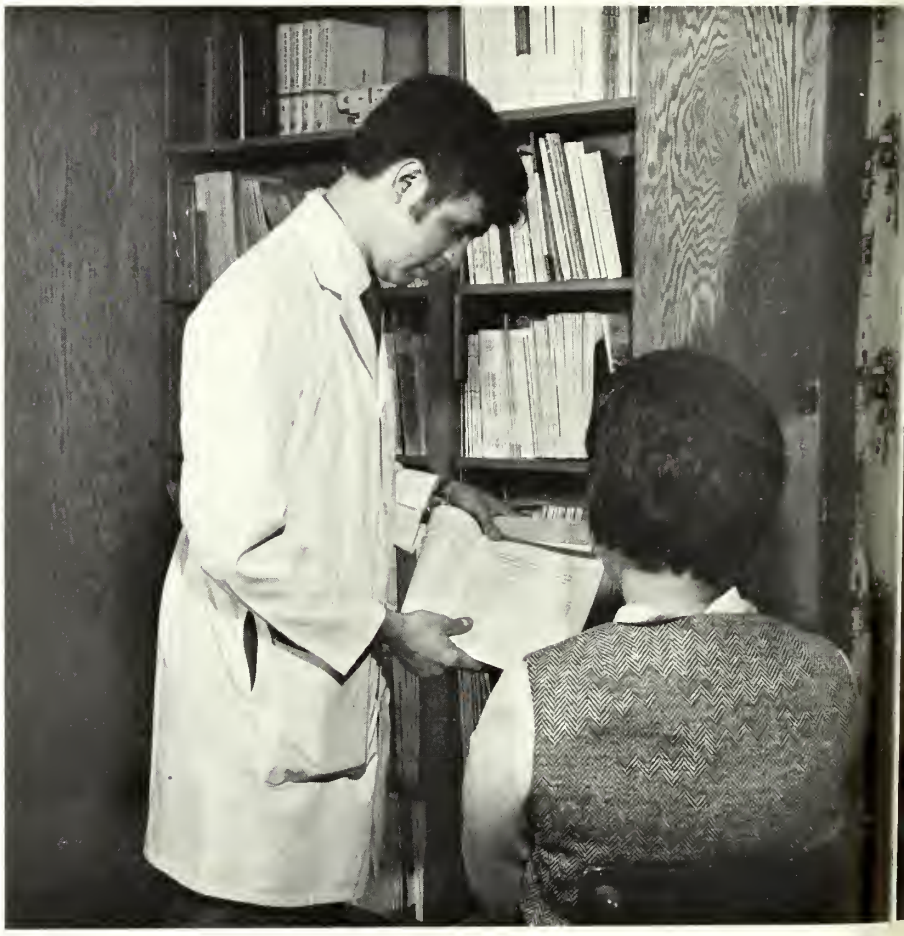
Reach to Recovery is not a club and a woman is encouraged to return to her normal way of life as soon as possible. Mastectomy patients are offered no morale-destroying pity or sympathy. They are offered living proof and assurance that they are just as much a woman, just as much a person, as they ever were. This, plus the practical assistance provided, helps in getting a woman back to the important things in living.

While the benefits to the patient are the prime asset of this program, the advantages of the service for the surgeon and physician should not be overlooked. The demands and pressures on every member of the medical profession and his staff continue to increase. Here is a service which the physician may make available to his patients and which will save time for him and his staff. He may offer this assistance to his patient without cost and without interfering with the doctor-patient relationship.

Another very important part of the Reach to Recovery program is the education of personnel responsible for the comfort of the radical mastectomy patient. This takes the form of lectures and demonstrations to nursing schools of large hospitals, staff physicians, medical students, graduate and undergraduate nurses, social service workers, and other interested personnel. These lectures include creation of an awareness of the patient's reaction to her operation, demonstration of exercises, showing prosthesis and how they are worn, including a display and discussion of bathing suits, demonstration of elastic, pressure and pneumatic sleeves (to be used only with the physician's consent), and cosmetic devices for disguising discolorations and scars.

Single copies of Reach to Recovery literature will be available from the division office to local units, physicians, and others interested in the Reach to Recovery Program. When the division receives requests for individual copies of the Reach to Recovery publications for patients, it will supply them to physicians and nurses.

Further information on the American Cancer Society Reach to Recovery program is available by writing: Service Director, Pennsylvania Division, American Cancer Society, P. O. Box 4175, Harrisburg, Pennsylvania 17111.



CANCER FORUM — presented cooperatively by the PMS Council on Education and Science, The Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health.

Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Informotion—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indicotions:** For the prevention and treotment of nocturnal ond recumbency leg muscle cromps, including those associoted with arthritis, diobetes, varicose veins, thrombophlebitis, orteriosclerosis ond static foot defarmities. **Contraindicotions:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precoutions/Adverse Reoctions:** Aminaphylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastraintestinal disturbance. Discantinue use if ringing in the ears, deafness, skin rosh, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessory, dosage may be increased ta one tablet following the evening meal and ane toblet upan retiring. **Supplied:** Bottles of 100 and 500 tablets.

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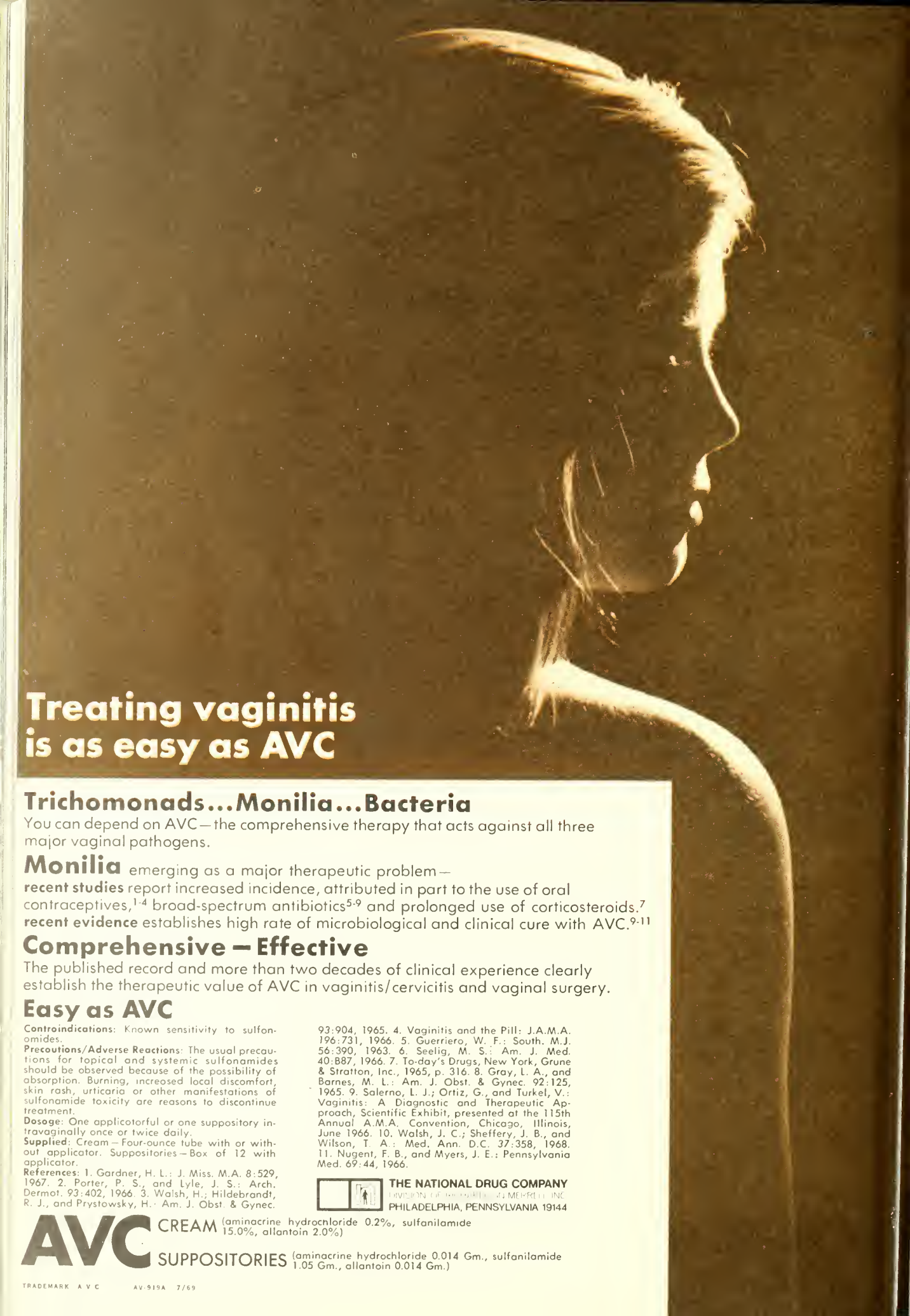
(quinine sulfate 260 mg., aminophylline 195 mg.)



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Controindications: Known sensitivity to sulfonomides.
Precoutions/Adverse Reactions: The usual precautions for topical and systemic sulfonamides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonamide toxicity are reasons to discontinue treatment.
Dosoge: One applicotorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermot. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

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TRADEMARK A V C

AV-919A 7/69

obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Clyde F. Peairs,** Sutersville; University of Pittsburgh School of Medicine, 1921. He had practiced medicine in this community for forty-seven years. He is survived by his wife and three daughters.

○ **David A. Roth,** Philadelphia; University of Pennsylvania School of Medicine; age 85; died April 20, 1969. No survivors are listed.

○ **Albin R. Rozploch,** Chester; Jefferson Medical College, 1917; age 77; died July 28, 1969. He served in the Army Medical Corps during World War I. He received the PMS Fifty Year Award in 1967 for his length of service in the medical profession. He is survived by his wife and a son.

○ **John R. Sabol,** Williamsport; Jefferson Medical College, 1957; age 40; died July 27, 1969. He had practiced orthopedic surgery in Williamsport since 1962. He is survived by his wife, Louise Justin Sabol, M.D., two daughters, his mother, and a sister.

○ **John S. Saling,** Pittsburgh; University of Pittsburgh School of Medicine, 1926; age 65; died August 12, 1969. He was for many years a member of the faculty of the University of Pittsburgh Dental School, and practiced medicine for forty-two years. He is survived by his wife, three sons and two sisters.

○ **Victor J. Wicks,** Ingomar; Baylor University College of Medicine, 1943; age 56; died July 17, 1969. He is survived by his wife, one son and three daughters.

○ **Louis Russell Wiley,** Hanover; Medico-Chirurgical College of Philadelphia, 1912; age 80; died July 27, 1969. He was a diplomate of the American Radiological College. Surviving are his wife, a son, a daughter, a step-daughter and a sister.

Howard H. Bradshaw, Winston-Salem, N. C., Jefferson Medical College, 1927; age 65; died August 11, 1969. He was professor of surgery at Jefferson Medical College and in 1941 became professor of surgery at Bowman-Gray Medical College in Winston-Salem. Surviving are his wife, two sons, a daughter and a brother.

Robert A. Christman, Newfoundland; Harvard Medical School; age 80; died August 5, 1969. He served in the Army Medical Corps during World War I. He is survived by a son, a daughter and a brother.

Louis Donaldson, M. D., Ligonier; Jefferson Medical College, 1900; age 95; died July 10, 1969. He served in the Army Medical Corps during World War I. He is survived by three sons

Louis Goss, Philadelphia; Jefferson Medical College, 1930; age 67; died May 9, 1969. He is survived by his wife.

Joseph Handler, Philadelphia; University of Pennsylvania School of Medicine, 1907, age 83; died August 14, 1969. He had been a general practitioner for sixty-one years until his retirement in 1968. Surviving are three sons, including S. Herbert Handler, M.D.

Russell M. Hartman, Fleetwood; Jefferson Medical College, 1930; age 64; died July 28, 1969. He is survived by his wife, two daughters, two sons and a sister.

Hugh Hayford, Altoona; Temple University School of Medicine, 1923; age 82; died May 18, 1969. He is survived by his son, Hugh Hayford, Jr., M.D., Altoona.

Jennie M. McKee, Philadelphia; Woman's Medical College, 1916; age 86; died April 24, 1969. No survivors are listed.

Jacob Pearl, Philadelphia; University of Pennsylvania School of Medicine, 1912; age 79; died May 23, 1969. No survivors are listed.

Harold M. Tuberty, Sayre; University of Pennsylvania School of Medicine, 1921, age 75; died July 31, 1969. He is survived by a son.

○ **James Balph, Jr.,** Pittsburgh; Jefferson Medical College, 1920; age 77; died August 22, 1969. He had practiced medicine in Pittsburgh for forty-eight years. Surviving are his wife, a daughter, a son and a brother.

○ **Walter D. Blankenship,** Neffsville; College of Physicians and Surgeons, Baltimore, Md., 1910; age 83; died August 16, 1969. He had practiced medicine in Lancaster for more than fifty years, and was a recipient of the PMS Fifty-Year Award. Surviving are his daughter, wife of John A. Bromer, M.D., Westport, Conn., and his son, Albert B. Blankenship, M.D., of Don Mills, Ontario, Canada.

○ **Joseph E. Campbell,** Wynnewood; Harvard University Medical School, 1951; age 44; died August 23, 1969. Dr. Campbell was chief forensic pathologist in the Philadelphia Medical Examiner's Office. He received his law degree from Temple University in 1964 and earned the degree of master of law in 1965. He had board certifications in anatomical pathology, clinical pathology and forensic pathology, and was working toward a Ph.D. in pharmacology and toxicology at the time of his death. He is survived by his wife and three children. A memorial library in his honor is being established in the Office of the Medical Examiner in Philadelphia. Contributions may be sent to the Joseph Edward Campbell Memorial Library, c/o Joseph E. Spelman, M.D., Thirteenth and Wood Sts., Philadelphia.

○ **Leonadas T. Drivas,** Philipsburg; University of Pittsburgh Medical School, 1950; age 48; died August 23, 1969. He was head of the emergency room at Philipsburg State General Hospital and was long active in promoting Boy Scout activities. He was recipient of the Silver Beaver award, "for distinguished service to scouting," and was a member of the Order of the Arrow. He is survived by his mother, a sister and a brother.

○ **Thomas G. McLellan,** Connellsville; University of Toronto Faculty of Medicine, 1924; age 70; died July 2, 1969. He was a diplomate of the American Board of Ophthalmology and a past president of the Fayette County Medical Society. He served with the Canadian Tank Battalion in Europe during World War I. Survivors include his wife, a son, Thomas G. McLellan, Jr., M.D., and two sisters. (This announcement appeared previously with an incorrect name spelling.)

A list of educational opportunities offered to physicians in the interest of maintaining their competence and skill. Unless otherwise indicated, all courses are designed for physicians engaged in primary patient care.

ARTHRITIS AND RHEUMATISM

November 12, 1969; Philadelphia

C—**The Painful Shoulder and Painful Back;** at Albert Einstein Medical Center; 6 hours AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Chmn., Educ. Comm., AEMC, York & Tabor Roads, Philadelphia 19141.

CARDIOVASCULAR DISEASE

November 5, 1969; Allentown

I/AMA—**Reversible Cerebral Vascular Insult** (8 week Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hospital; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp.; Allentown 18102.

November 18, 1969; Chester

I/AMA—**Innocent Murmurs—Don't Make Them Cardiac Cripples** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 20, 1969; Altoona Hospital

I/AMA—**Myocardial Infarction, Consecutive Case Conference** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

CHEST DISEASES

November 10-21, 1969; Philadelphia (Repeat February 9-20, 1970 and April 6-17, 1970)

PG/AMA—**Postgraduate Course in Bronchoesophagology;** at Temple; for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. $350 fee. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

DERMATOLOGY

November 20, 1969; Williamsport Hospital

I/AMA—**Office Management of Common Dermatologic Problems;** (Postgraduate Seminars held 3rd Thurs. ea. mo.); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

"CODE KEY"

C—Consecutive days
I—Intermittent
O—Circuit
PG—Postgraduate Trainee ship
R—Radio
TV—Television
S—Designed for full-time specialists
AMA—AMA Accredited Institution

C E S—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Penn-Grad—University of Pennsylvania, Division of Graduate Medicine
Pitt—University of Pittsburgh School of Medicine
Pitt P.H.—University of Pittsburgh Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania School of Medicine
Woman's—Woman's Medical College of Pennsylvania

ENDOCRINOLOGY

November 3, 1969; Philadelphia

I/AMA—**Current Concepts of the Diagnosis and Treatment of Thyroid Diseases** (Program of Continuing Medical Education—1st Mon., 8 mos.); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 20-21, 1969; Erie

I/AMA—**Thyroid Disease: Diagnosis and Treatment** (Program of Continuing Medical Education—twice a month; Sept.-Dec.); by Jefferson and Penn State; at St. Vincent Hosp.; 3 hrs. AAGP credit; Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

GASTROENTEROLOGY

November 19, 1969; Sewickley Valley Hospital

I—**Peptic Ulcer** (Current Medical-Surgical Aspects of Gastrointestinal Problems—3 consecutive Wed. afternoons); in association with Cleveland Clinic; 3 hrs. AAGP credit. Contact Mrs. Myers, Med. Staff Secy., Sewickley Valley Hosp., Blackburn Rd., Sewickley 15143.

November 20, 1969; Pottsville

I/AMA—**Pancreatitis** (Continuing Education Series—3rd Thurs., 8 mos.); by Hahnemann; at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

November 26, 1969; Sewickley Valley Hospital

I—**Diseases of Small and Large Intestines** (Current Medical-Surgical Aspects of Gastrointestinal Problems—3 consecutive Wed. afternoons); in association with Cleveland Clinic; 3 hrs. AAGP credit. Contact Mrs. Myers, Med. Staff Secy., Sewickley Valley Hosp., Blackburn Rd., Sewickley 15143.

December 3, 1969; Sewickley Valley Hospital

I—**Diseases of the Liver** (Current Medical-Surgical Aspects of Gastrointestinal Problems—3 consecutive Wed. afternoons); in association with Cleveland Clinic 3 hrs. AAGP credit. Contact Mrs. Myers, Med. Staff Secy., Sewickley Valley Hosp., Blackburn Rd., Sewickley 15143.

GENERAL MEDICINE

Every Thursday; Hazleton State General Hospital

I—**Program of Continuing Medical Education by Hazleton Branch, Luzerne County Medical Society.** Contact Robert Gunderson, M.D., Suite 412 Northeastern Building, Hazleton, Pa. 18201.

November 5–April 15, 1970; Lock Haven Hospital

I—**Current Medical & Surgical Concepts** (Program of Continuing Medical Education—Altern. Wed., 10 sessions); by C E S, 30 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Road, Lemoyne 17043.

November 6-7, 1969; Erie

I/AMA—**Cervical Spine: Injuries and Arthritis** (Program of Continuing Medical Education—twice a month, Sept.-Dec.); by Jefferson and Penn State; at St. Vincent Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

November 11, 1969; Chester

I/AMA—**Principals of Cerebral Localization** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 13, 1969; York Hospital

I/AMA—**Recent Advances in Treatment of Renal Calculi** (Program of Con-

(Cont'd. on Page 126.)

★

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tinuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 14, 1969; Williamsport Hospital

1/AMA—**Hormonal Contraceptives—Indications and Contraindications** (Program of Continuing Medical Education—2nd Thurs. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

November 20, 1969; Bethlehem

1/AMA—**Immunologic Basis of Hematologic Diseases** (Program of Continuing Medical Education); by Jefferson & Penn State; At St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 20, 1969; York Hospital

1/AMA—**Pulmonary Reserve, Body Habitus, and Anesthesia Risk** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

November 12 and 13, 1969; Reading Hospital

C—**Two Days of Hematology;** AAGP credit applied for; $25 fee ($10 for interns, residents, fellows & students). Contact Charles J. Lusch, M.D., Reading Hospital, Reading 19602.

INTERNAL MEDICINE

November 4, 1969; Lebanon

1/AMA—**Headaches: Causation and Treatment** (Continuing Medical Education Program—1st Tues., 4 mos.); by Jefferson and Penn State; at Quentin Riding Academy; 2 hrs. AAGP credit $8 fee ($35 for 4 sessions). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

November 19, 1969; Reading

1/AMA—**Connective Tissue Disorders** (Continuing Education Series—3rd Wed., 8 mos.); by Hahnemann; at Community Gen. Hosp. Contact Paul K. Stolz, M.D., Dir., Continuing Education, Community Gen. Hosp., 135 N. 6th St., Reading 19601.

November 20, 1969; Philadelphia

C/AMA—**Office Management of Diabetes and Its Complications;** at Albert Einstein Medical Center; 6½ hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

November 25, 1969; Chester

1/AMA—**Clinical Approach to Common Arrhythmias** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

MALIGNANT DISEASE

November 5, 1969; Franklin

C/AMA—**Chemotherapy of Malignancies;** by Jefferson, Penn State and Franklin Hosp.; at Voyager Motor Inn; 3 hrs. AAGP credit; $10 fee. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

November 19–December 17, 1969; Philadelphia (Repeat 5 times: January 7, February 11, March 18, April 22 and May 27, 1970).

1—**Cancer Detection in Office Practice** (5 consecutive Wed. afternoons); by American Cancer Society; at American Oncologic Hosp.; 20 hrs. AAGP credit; limited to 8 per group. Contact Joseph G. Strawitz, M.D., Assoc. Dir., American Oncologic Hosp., Central & Shelmire Aves., Philadelphia 19111.

OBSTETRICS & GYNECOLOGY

November 13, 1969; Allentown Hospital

1/AMA—**Diabetes and Pregnancy** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PEDIATRICS

November 20, 1969; Wilkes-Barre General Hospital

1/AMA—**Fevers of Unknown Origin in the Pediatric Age Group** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Fourth Friday each month, September, 1969—June, 1970; Butler

1—**Physician-Community Psychiatrist Seminar;** by Mental Health Guidance Clinic of Butler Co.; at YWCA; Hour for hour AAGP credit. Contact Robert L. Eisler, M.D., Mental Health Guidance Clinic, 128 S. Main St., Butler 16001.

November 1-2, 1969; Philadelphia

C—**Psychiatry 1969 for the General Practitioner;** by Temple; at Marriott Motor Hotel; 13 hrs. AAGP credit applied for; $40 fee. Contact Barney M. Dlin, M.D., Temple, 3401 N. Broad St., Philadelphia 19140.

November 6, 1969—January 8, 1970; Harrisburg Hospital

1/AMA—**Management of Psychiatric Problems in Medicine;** by Hahnemann—Each Thursday, 7 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

November 12, 1969—January 28, 1970; Philadelphia

1—**Advanced Office Psychiatry and Psychosomatic Medicine;** at Temple—Each Wednesday, 10 weeks; 30 hrs. AAGP credit; $40 fee. Contact Barney M. Dlin, M.D., Director, Department of Psychiatry, Temple, Broad & Ontario Sts., Philadelphia 19140.

RADIOLOGY AND RADIOISOTOPES

November 25, 1969; Johnstown

1/AMA—**Current Status of Radio-Isotope Scanning** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

SURGERY

November 19, 1969; Scranton

1/AMA—**Postoperative Complications: Prevention of and Treatment Should They Occur** (Program of Continuing Medical Education—3rd Wed. ea. mo., 8 mos.); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP Credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

UROLOGY

November 6, 1969; York Hospital

1/AMA—**When and What Kind of Prostatectomy** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

meetings

Tuberculosis and Respiratory Disease Association Annual Meeting, "Air Pollution and Health," November 6, 1969, at Jefferson Medical College and Hospital.

American Society of Cytology Seventeenth Annual Scientific Meeting, November 6-8, 1969, Palmer House, Chicago, Ill.

American Public Health Association Annual Meeting, November 10-14, 1969, Civic Center, Philadelphia.

American Heart Association Annual Scientific Sessions and Assembly, November 13-18, 1969, Fairmont Hotel, Dallas, Texas.

American Fracture Association, November 9-13, 1969, Sheraton-Columbus Motor Hotel, Columbus, O.

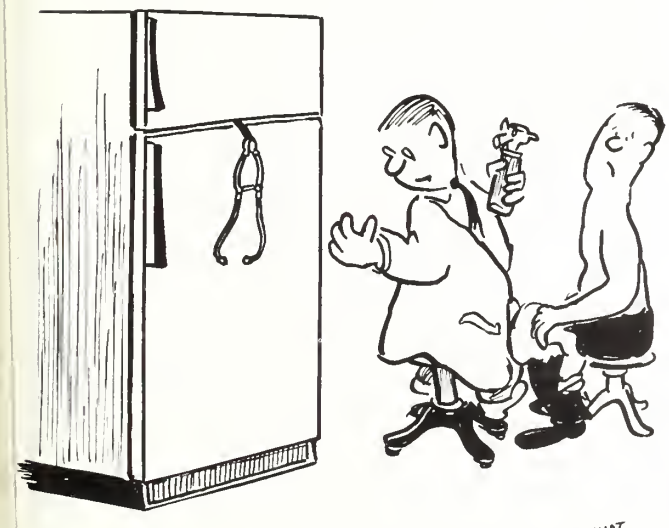
Eastern Pennsylvania Chapter, American College of Surgeons, November 12, 1969, at Hotel Bethlehem, Bethlehem, Pa.

The Academy of Psychosomatic Medicine, November 19-23, 1969, at Mountain Shadows Inn, Scottsdale, Ariz.

Institute of Medicine of Chicago, "Delivery of Medical Care in the 1970's," November 21-22, 1969, Ambassador Hotel, Chicago, Ill.

Arthritis Foundation, Allied Health Professions, December 4, 1969; American Rheumatism Association Interim Scientific Session, December 5-6, 1969, Pioneer Hotel, Tucson, Ariz.

AMA Clinical Convention, November 30-December 3, 1969, Convention Center, Denver, Colo. House of Delegates will meet at the Denver Hilton Hotel.



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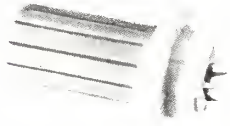

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Emergency Room Physicians—full-time; accredited 300-bed general hospital; active, approved internship and residency programs; excellent benefits. Submit resume to: Administrator, Robert Packer Hospital, Sayre, Pa. 18840.

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Physician for Student Health Service. Easy hours, pleasant work, excellent fringe benefits. Equal opportunity employer. Write: Director, Student Health Service, Lehigh University, Bethlehem, Pa. 18015.

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Full-time staff psychiatrists in 1555-bed active neuropsychiatric hospital affiliated with Jefferson Medical College, Philadelphia. Salary from $18,000 to $25,000 per annum depending on experience and qualifications; liberal retirement, vacation and sick benefits. Dynamic, progressive program in clinical and research psychiatry. An equal employment opportunity agency. Apply to Hospital Director, VA Hospital, Coatesville, Pa. 19320.

House Physicians (three) needed at 235-bed JCAH accredited short-term, general hospital in suburban Philadelphia. Established educational program and residency in general surgery. $14,000 per annum plus benefits. Excellent practice opportunity in growing area. Pennsylvania license required. Contact Bruce R. Marger, M.D., Sacred Heart Hospital, 1430 DeKalb St., Norristown, Pa. 19401.

Emergency room physician—immediate opening in an accredited 300-bed acute care hospital located in the prosperous Mid-Ohio Valley. West Virginia license required. Average forty-forty-five hours per week. Salary $30,000 yearly guarantee. Four weeks vacation, plus one week for medical meeting. Submit complete curriculum vitae to Department 559, PENNSYLVANIA MEDICINE.

Board eligible or certified internist wanted for a new 196-bed hospital in northwest Pennsylvania. Community of 15,000. Hospital staff will guarantee generous net for first year of practice. Write Department 564, PENNSYLVANIA MEDICINE.

Beautiful Bedford County needs physicians in private practice. Excellent opportunity. Well-equipped local hospital with open staff expanding to 115 beds with four-bed ICC unit. Resort community with newly acquired light and heavy industry. Hunting, fishing, skiing, boating and three golf courses. Excellent school system. No big-city problems. Two hours from Harrisburg, Pittsburgh, Washington, D. C. Contact M.D. Search Committee, Memorial Hospital of Bedford County, R. D. 1, Everett, Pa. 15537.

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Board eligible or certified pediatrician wanted for 200-bed hospital in western Pennsylvania with 30,000 service population. Will provide moving expenses and guaranteed net for first year. Write Department 563, PENNSYLVANIA MEDICINE.

SITUATIONS WANTED

Psychiatrist has two or three hours available Saturday mornings. Industrial, educational or clinic evaluation and therapy. Pittsburgh area. Write Department 560, PENNSYLVANIA MEDICINE.

Internist, age thirty-one, board eligible. University of Pennsylvania graduate, completing cardiology fellowship. Diabetes and metabolism fellowship completed; military service completed. Desires association or partnership in Philadelphia environs. Available July, 1970. Contact Barry Zitomer, M.D., 14501 A Del Amo St., Santa Ana, Calif. 92705.

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Internal Medicine practice for sale; will introduce. Florida license required. Write P.O. Box 4481, Miami Beach, Fla. 33141.

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PENNSYLVANIA MEDICINE

in my opinion

Let's Improve the Image

At the risk of suspicion as to literary taste, let me quote a few lines from Robbie Burns, Scotland's greatest poet:

"O wad some Power the giftie gie us
To see ourscls as ithers see us!
It wad frae mony a blunder free us
An foolish notion. . ."

It seems very likely that some of the blunders of organized medicine over the years, at all levels, might have been avoided if we had listened more and talked less. Too much of our conversation is among ourselves, and too much of our listening is to each other.

Because of this tendency toward ingrown discussion, we are often shocked to find intelligent and informed community leaders who either know little of our viewpoints, or knowing much disagree violently.

The lay public is not all-knowing about medical matters, but the percentage of jackasses among them is not much different than it is among us.

Not long ago a community group in Richmond County, Georgia held a discussion on medical matters, and a summary of observations appeared in the Medical Bulletin of the Richmond County Medical Society.

Here is a list:

1) The cost of medical care is high, probably too high, and going up.
2) Physicians' incomes are excessive and the difference in income between the physician and other scientific professions with advanced training is unjustifiable.
3) There are not enough physicians or paramedical personnel.
4) Medicine stifles competition by limiting numbers of newcomers, which then produces high fees. A corollary to this is a suspicion of an artificial restriction of entry into medical schools and the number of medical schools. Both suspicions are laid on the AMA doorstep.
5) Lay hospital boards are rubber stamps for the medical staff.
6) Physicians profit by long hospital stays of patients, which causes hospital bed shortages.
7) Medicare is being exploited by the physician.
8) Putting physicians on salaries would solve much of this.

The first reaction to this list is astonishment tinged with sadness. How could people be so wrong about little old us? Another reaction is that this is just another form of doctor-baiting that has gone on for centuries.

But let us deal with the facts. Are we to blame for the high cost of medical care? If so, are we doing anything about it. It not, then why haven't we gotten our explanations over to the public?

Are there other professions, equal in training to ours, wherein the financial returns are notably less? Again, if so, why aren't our explanations acceptable?

Are we doing all we can to increase the flow of young physicians, and of paramedical technicians? If so, why don't we speak up? If not, how do we improve matters?

This particular string of complaints is merely another one that says our image is tarnished around the edges. But it seems to me that it is the image of expectancy that is tarnished, not that of the doctor. Several studies show that the criticism of medicine, as a whole, are almost never applied to a person's own physician. That particular doctor is never blamed—it's always the "other doctors."

Since doctor-critics have been with us so long, they likely will be around quite a spell longer, and the barrage from newspapers, magazines, radio and television probably will not lift.

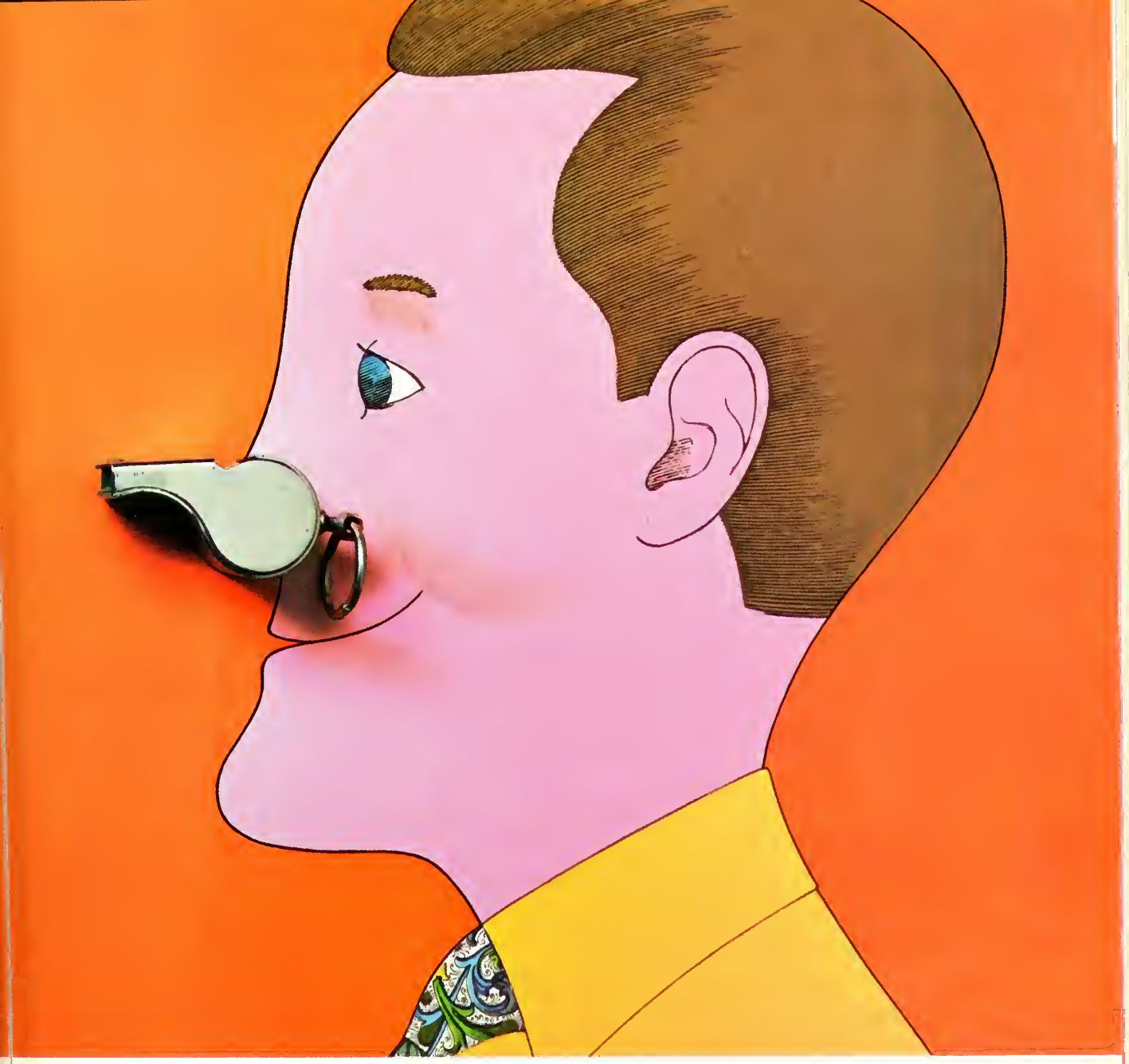
What remains then for us to undertake is a counter-barrage, since we can't stay in our foxholes forever. The counter-barrage of the individual physician is not going to do much, since he is already exempted from the fray. It must come from organized medicine at all levels—county, state and national, and must be an offensive barrage and not a defensive one.

A public relations program such as the AMA launched against Medicare is not the likely answer. This program must be on the local level. Public interest in medical matters is always at a high pitch. Furnishing local papers, radio and television stations with speakers and news releases is necessary. Having speakers available for every call for a speaker at a civic group meeting is a must.

But the county society cannot operate without the help of its members. If you hear of a group that needs a speaker, say the medical society has speakers available. Then let the society know about it. If you see an offensive story in your local paper, tell us by mail or phone, as quickly as possible, so we can counter-attack. Be alert for chances to tell our story.

Not only need we see ourselves as others see us, but we need to tell others how we see ourselves.

Bruce H. Carney, M.D.
Montgomery County Medical Bulletin



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Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
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Supplied: Bottles of 100 and 500.

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The compound analgesic that calms instead of caffeinates

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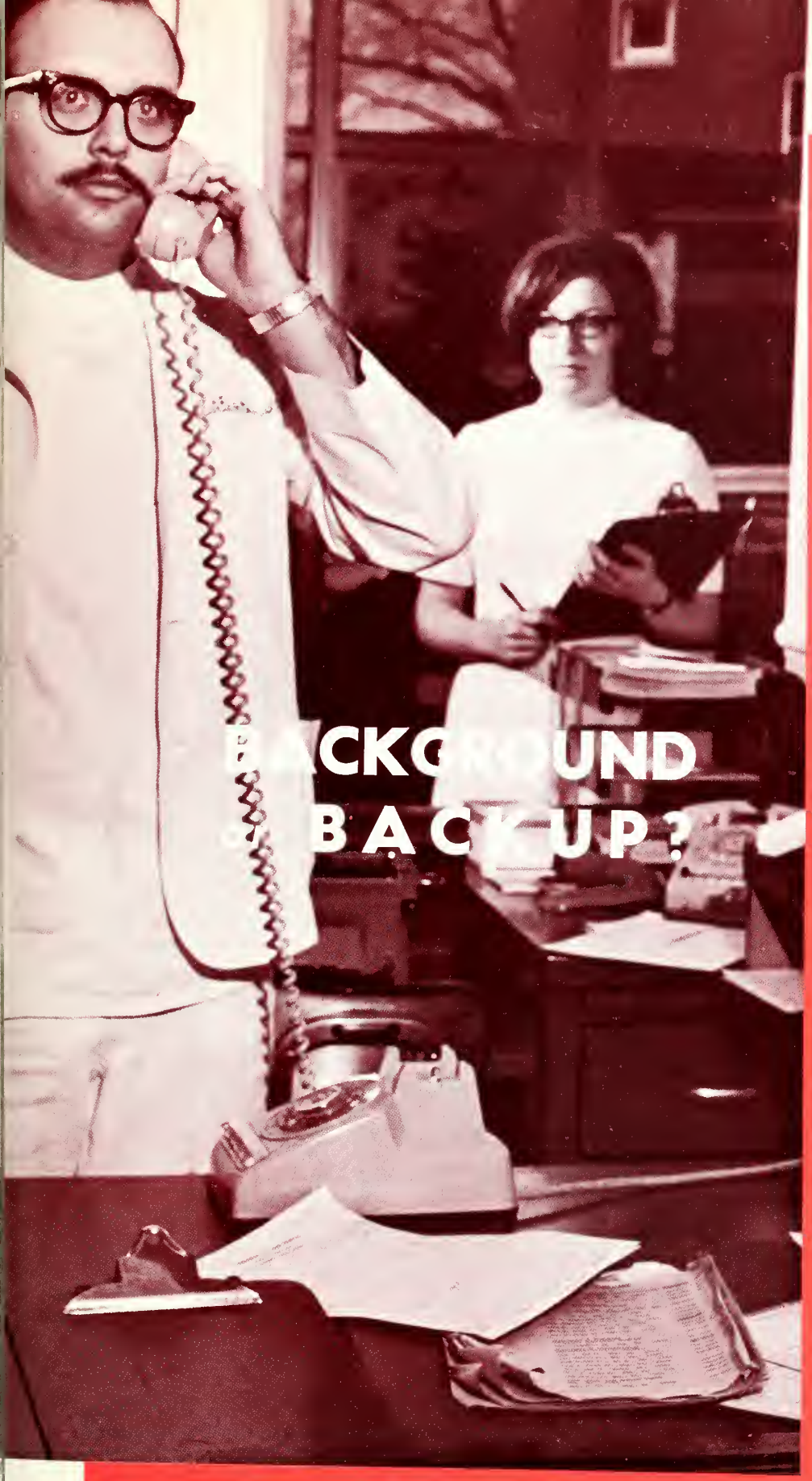

ACKG UND BACK UP?

When you think about all your medical assistant does for you, she is almost like an extra set of hands! On top of all she accomplishes now, you can help her do a better, more efficient job. Encourage her to be active in the county, state and national Association of Medical Assistants.

Through her county and state associations, your "Gal Friday" can pick up valuable knowledge that will assist you and her in everyday work at the office.

OBJECTIVES OF THE ASSOCIATION of MEDICAL ASSISTANTS

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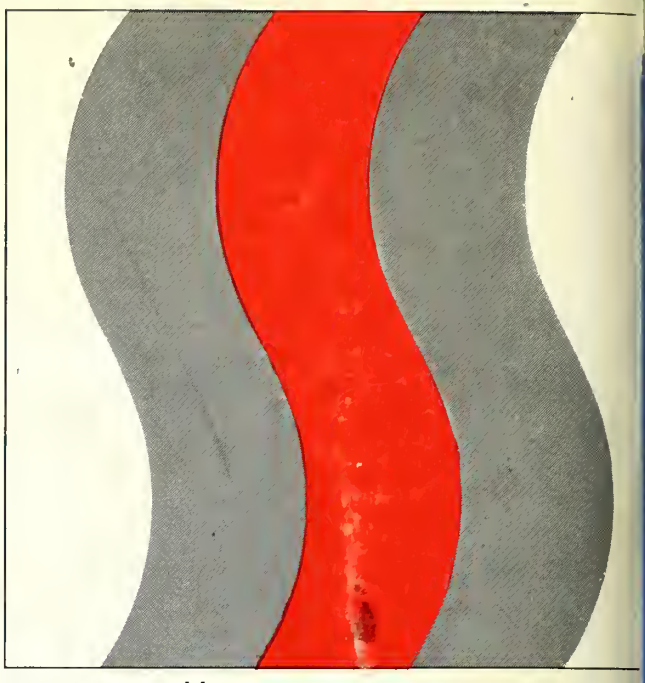
For Further Information, Write: Pennsylvania Medical Society Council on Public Service

from the discord of anxiety...



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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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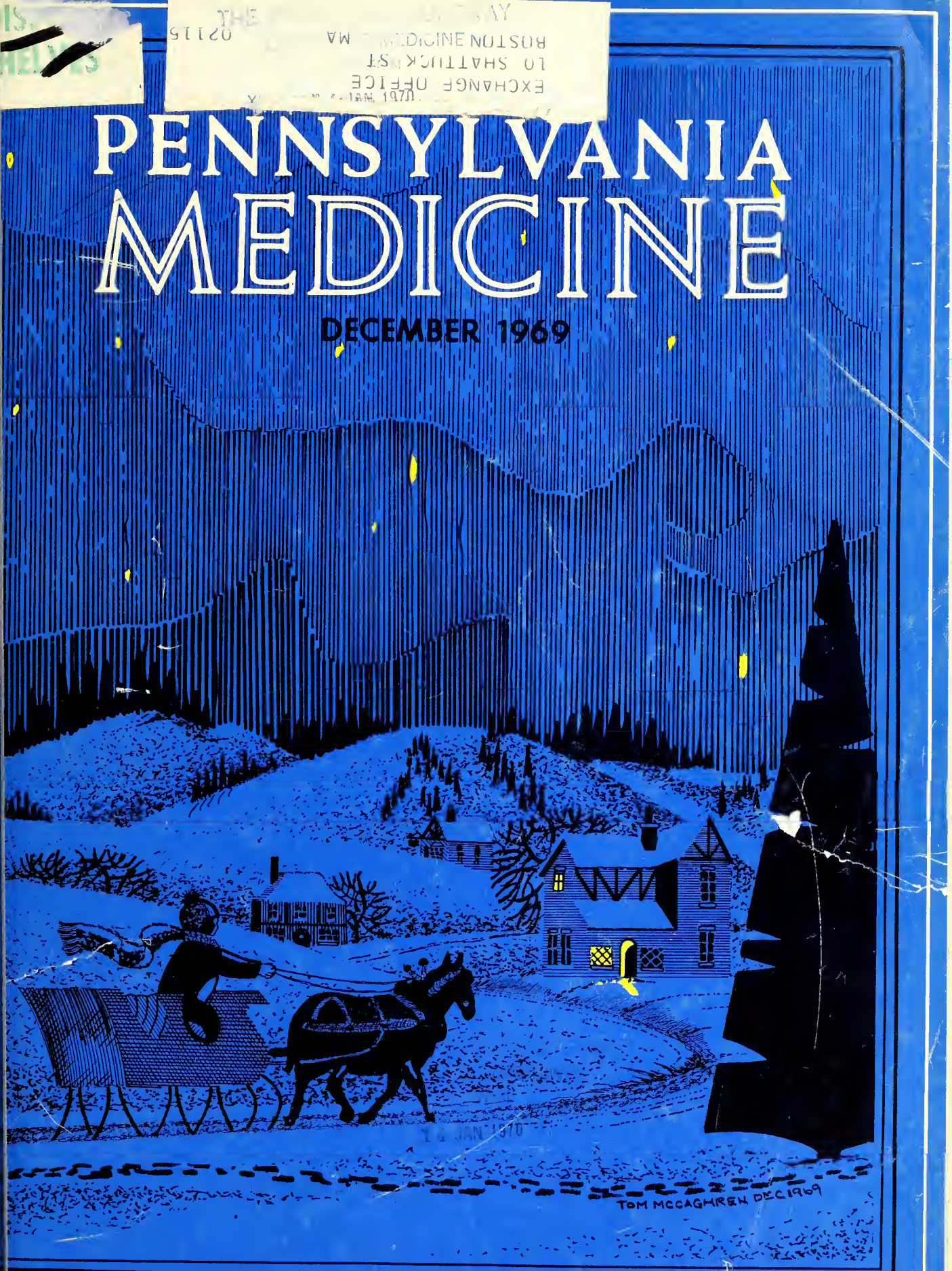
PENNSYLVANIA MEDICINE

DECEMBER 1969



Holiday House Call

Season's Greetings

FROM THE EDITORS AND STAFF OF PENNSYLVANIA MEDICINE

PENNSYLVANIA MEDICINE

/medigram

DECEMBER, 1969

14 JAN 1970

PMS PAST-PRESIDENT DIES Moses Behrend, M.D., Philadelphia, 92, president of the Pennsylvania Medical Society in 1934, died at his home on November 15, 1969. Dr. Behrend, who attended the State Dinner at the 120th Annual Session of the PMS House of Delegates in October, remained active in medical society affairs until his death.

NEW MEDICARE RULES AFFECT M.D.'S Physicians, effective January 1, 1970, must certify the necessity of services given hospitalized medicare patients on the 12th and 18th day of hospitalization instead of the current certification requirements on the 14th and 21st days. HEW is attempting to reduce costs by reducing certification time.

FAMILY PRACTICE EXAMS SET The first examinations for certification of the new American Board of Family Practice will be held throughout the nation February 28 and March 1, 1970. The Board reported a flood of applications for the certification exams prior to the November 31 deadline.

PENNSYLVANIAN SERVES NATIONAL COUNCIL David O. Maxwell, Pennsylvania Secretary of Administration and Budget Secretary, has been named by HEW Secretary Robert Finch to serve as a member of the national Medical Assistance Advisory Council.

STATE TASK FORCE INCLUDES M.D.'S George R. Moffitt, Jr., M.D., Harrisburg, and P. K. Pandelidis, M.D, York, have been appointed by James Z. Appel, M.D., Lancaster, to serve the state Task Force on Personal Health Services. Dr. Appel is chairman of the Task Force which will study the quantity and quality of existing health facilities and services and manpower. The law requires that a majority of the members be consumers.

MEDICINE/GOVERNMENT LIAISON POSTURE IMPROVING The Pennsylvania Medical Society is leaving no stone unturned in its determined effort to achieve a closer liaison with officials responsible for governmental health programs according to Matthew Marshall, Jr., M.D., chairman of the PMS Council on Medical Service. "The...Council...continues to devote considerable time and effort to developing practical and effective methods to assure proper use of prepaid health care dollars under both Medicare and Medicaid (Pennsycare)." Dr. Marshall does not hesitate to say

that there are obviously many problems that remain to be resolved, but in order to develop better understanding of organized medicine's efforts in the area of utilization review, Theodore C. Bedwell, M.D., chief medical officer, SSA Bureau of Health Insurance, spent three days during October in a series of meetings with representatives of the PMS, Blue Cross of Western Pennsylvania, and the Hospital Utilization Project observing the efforts and discussing mutual problems. Also in attendance at the meetings were federal and state Medicaid officials. Subsequent to the meeting, Dr. Marshall received a letter from Dr. Bedwell in which the SSA official said: "The time I spent in Pittsburgh with you and all of the other people was of tremendous help to me...You and Western Pennsylvania are to be commended for the spirit of cooperation and sincere dedication to the task of providing good medical care and in seeing that it is delivered at the appropriate level. I was quite impressed with the operation of the Committees."

AMA PLAN PRESENTED

The AMA's income tax credit proposal to finance the purchase of voluntary health insurance was presented by Russell B. Roth, M.D., Erie, at hearings before the House Ways and Means Committee in Washington. The program would take the place of Medicaid. Under the AMA plan, called "Medicredit", cash incentives would be offered for the purchase of comprehensive health insurance. The incentive would range from 100 percent of the cost of such insurance for those with a tax liability of $300.00 or less to a minimum of 10 percent for those having a liability of more than $1,300.00. The approved policies would carry a $50.00 deductible on in-patient services and a 20 percent co-insurance on the first $500.00 of medical services and on the first $500.00 of expenses incurred for emergency room and out-patient services.

SENATE MOVES ON ANATOMICAL GIFTS ACT BILL

The Pennsylvania Senate last month finally moved on House Bill 2, the "Uniform Anatomical Gifts Act", with several weakening amendments, by a vote of 36-0. The amendments do not do irreparable harm to the bill, which now returns to the House of Representatives for concurrence on the amendments made in the Senate House sponsors of the bill have not indicated whether they will urge acceptance of the amendments, or raise objection to them, thus putting the bill in a conference committee of the House and Senate. If the amendments are accepted by the House, then the bill, which was introduced and passed in the House some months ago, will go to Governor Raymond P. Shafer for his signature and will become law.

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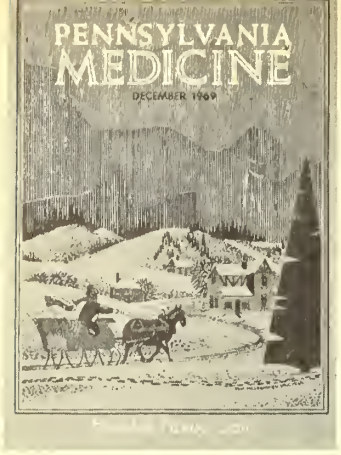

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JOURNAL OF THE PENNSYLVANIA MEDICAL SOCIETY

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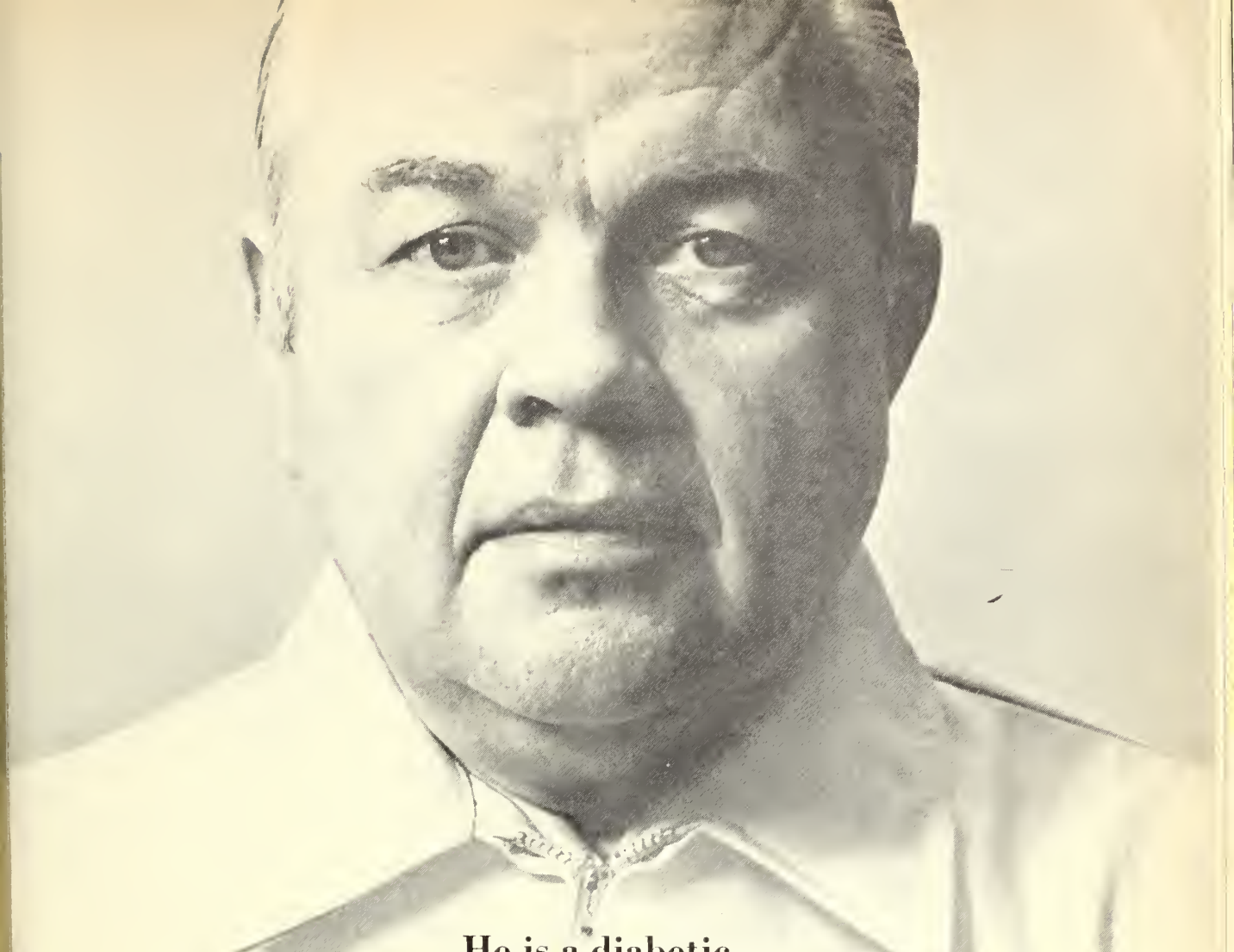

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Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of Nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

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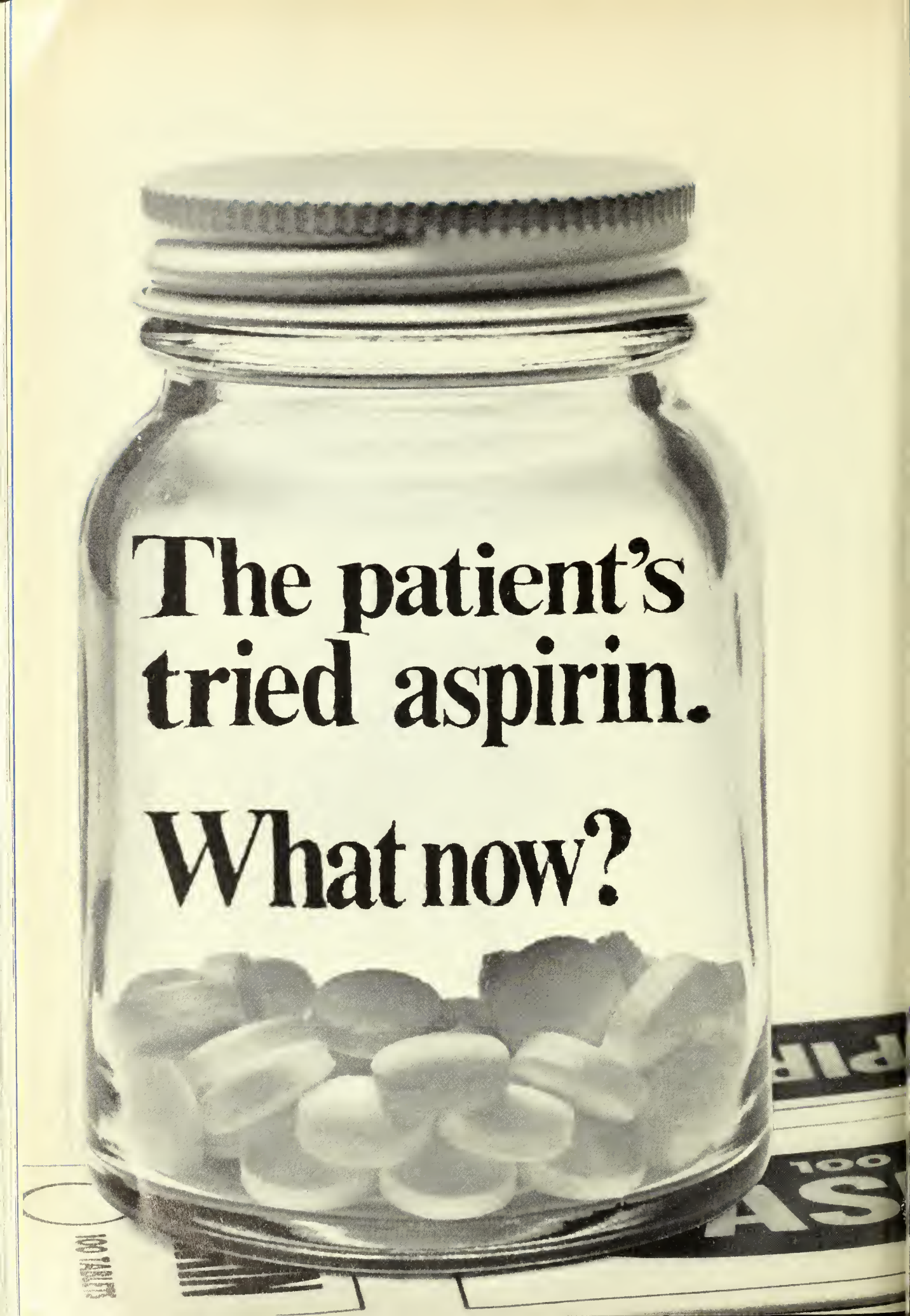
A Division of American Cyanamid Company, Pearl River, New York


The patient's
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Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . *and* associated anxiety and tension.

Tablets

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

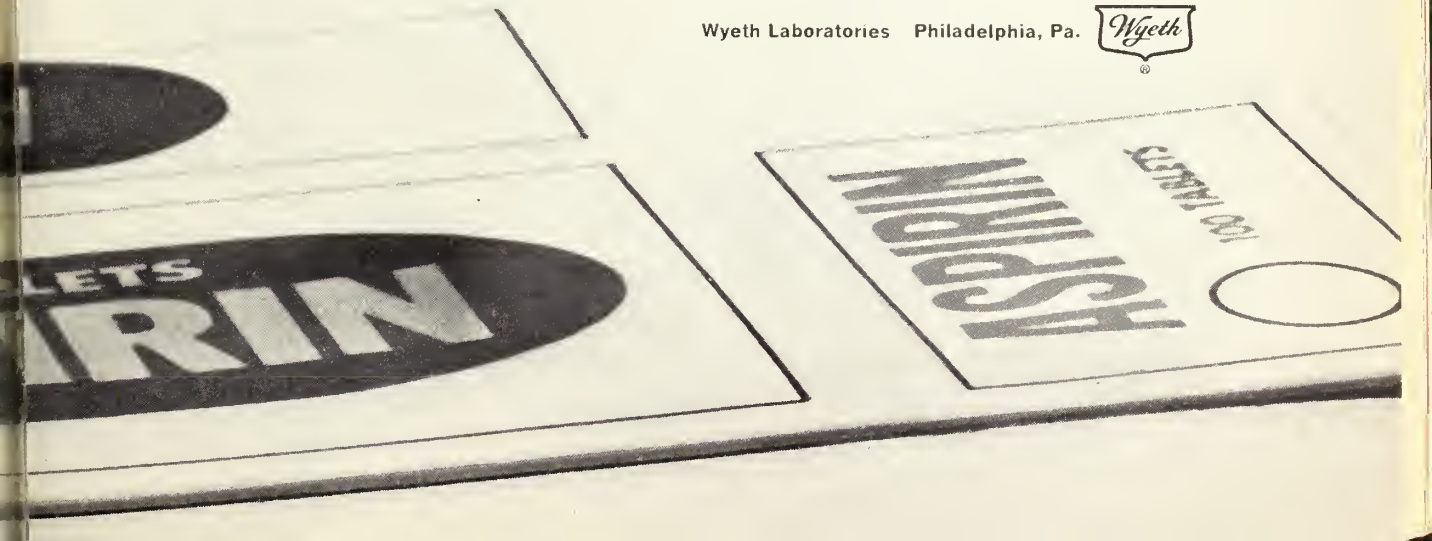
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



PENNSYLVANIA MEDICINE

newsfronts

Manpower, Education Discussed

PMS Council on Education and Science *met last month, under the chairmanship of Richard B. Magee, M.D., Johnstown, to discuss Society involvement with medical manpower problems; to lay the groundwork for continuing education for physicians at the 1970 PMS Scientific Assembly; to look into the possibility of requiring evidence of continuing education activities for Society membership; to review emergency medical services; to determine the feasibility of conducting a eugenic sterilization conference and to discuss Society involvement in preschool vision and hearing screening and support of sports medicine clinics.*

1969 PMS Roster Available

Copies of the 1969 PMS Roster, which includes the names of the 12,000 PMS members in alphabetical order throughout the state and in alphabetical order by county with complete, zip-coded addresses, is now available at Society headquarters.

PMS members are entitled to a complimentary copy. The cost per copy to non-members or organizations is $10.00.

A limited supply is available by sending requests to: Membership Department, Pennsylvania Medical Society, Taylor Bypass and Erford Rd., Lemoyne, Pa. 17043.

"Improving Drug Therapy" Subject of Competition

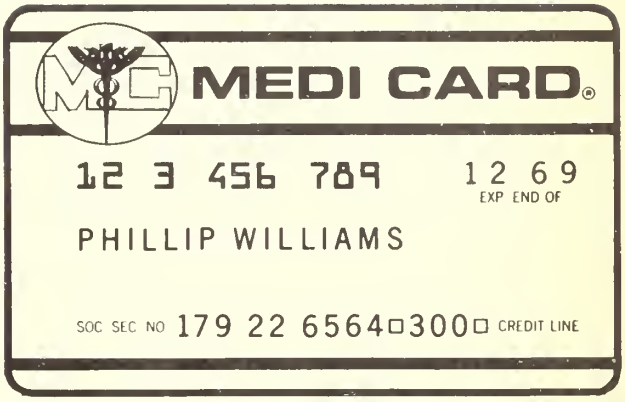
The United States Pharmacopeial Convention has invited full-time graduate and undergraduate students of accredited pharmacy and medical schools throughout the country to prepare papers on the topic, "The U.S.P. Role in Improving Drug Therapy."

The U.S.P. announced that two awards will be presented: one for the best paper submitted by a pharmacy student and one for the best paper submitted by a medical student. The winners will each receive an award of $250 and an expense-paid trip to the U.S.P.C. Sesquicentennial Meeting in Washington, D.C. in April, 1970.

Each pharmacy and medical school is being asked to select the two best papers submitted by students attending that school. The papers selected by each school will then be submitted to the U.S.P.C. for final selection. Only papers forwarded by the schools will be considered. Papers will be judged primarily on originality, practicality of ideas, clarity and organization of any proposals, composition, and adequacy of documentation.

The U.S.P.C. contest is but one part of the preparations for the 1970 Sesquicentennial Meeting. It is anticipated that this meeting will result in establishment of new policy and guidance aimed at giving the U.S.P. a larger role in providing the pharmacist and physician with information on U.S.P. drugs and drug products.

Also in preparation for the 1970 meeting, the U.S.P. staff is planning several one-day "retreats" in selected areas around the country. These retreats will provide an opportunity for mutual in-depth exploration of the opportunities and problems for the U.S.P.C. and the organizations that constitute it.



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Hospital Cost Hikes Effect Medicare Bene's.

Older people who enter the hospital under Medicare next January 1 or later will be responsible for an additional $8.00 of their hospital bills, a mandatory increase required by law.

The increase results from a provision in the law requiring an annual review of hospital costs under Medicare, and an adjustment of the portion of the hospital bill for which a Medicare beneficiary is responsible if these costs have risen substantially.

Medicare now pays all but the first $44 of a Medicare beneficiary's hospital bill in each spell of illness.

In announcing the increase in the deductible amount from $44 to $52, Robert M. Ball, commissioner of social security, noted that the hospital bill for an average stay by a Medicare beneficiary now runs about $700.

"The increase of $8 that a Medicare beneficiary will pay in his hospital bill effective in January," Ball said, "is a result of the long term trend toward increasing hospital costs and also, of course, results in part from the general inflation that has been taking place." "The Administration," he said, "is committed not only to bringing the general inflation under control but to working with the health community, insurance carriers and others so that the consumer will get more for the health care dollar."

The hospital deductible amount, Ball explained, is intended to make the Medicare beneficiary responsible for expenses equivalent to the average cost of one day of hospital care. It is similar to the deductible amounts provided in many auto insurance policies where the car owner pays the first $50 or $100 of a repair bill, and the insurance company pays the rest.

The law states that if this annual review shows that hospital costs have changed significantly, the hospital deductible must be adjusted for the following year, with any necessary adjustments made in $4.00 steps—to avoid small annual changes.

Ball said that when the hospital deductible amount changes, the law requires comparable changes in the dollar amounts that a Medicare beneficiary pays toward a hospital stay of more than sixty days, or a post-hospital extended care stay of more than twenty days. These amounts also will go up beginning January 1, 1970.

When a Medicare beneficiary has a hospital stay of more than sixty days he will pay $13 a day for the 61st through the 90th day, up from the present $11 per day. If he has a post-hospital stay of over twenty days in an extended care facility, he will pay $6.50 per day toward the cost of the twenty-first day through the 100th day, up from the present $5.50 per day.

If he needs to draw on his "lifetime reserve," the reserve account a beneficiary can draw upon if he ever needs more than ninety days of hospital care in the same benefit period, he will now pay $26 for each day used, instead of the present $22 per day.

PaMPAC Board Meets

The Board of Directors *of the Pennsylvania Medical Political Action Committee prepared a 1970 program during a meeting held at the time of the PMS Annual Session in Philadelphia. Joining the board's discussion under the chairmanship of William B. West, M.D., were Mr. Jerry Rothenberger, PaMPAC director, Mr. Chad P. Combs, assistant director, department of field services, division of public affairs of the AMA, Robert N. Smith, M.D., president of the Ohio State Medical Association, and Carl B. Lechner, M.D., past president of the Pennsylvania Medical Society. Subjects discussed included plans for a 1970 political action workshop, candidate support in 1970, improved liaison between the county medical societies and PaMPAC, increasing membership, a 1970 PaMPAC medico-political scholarship program, and follow-up on the "contact doctor system."*

On Filling Out Medicare Forms

Whenever a physician bills for an office consultation under the Medicare program, he must put on the bill the name of the doctor who referred the patient in order to avoid rejection of the claim or return of the form for additional information, according to The Subcommittee to Advise Blue Shield, PMS Council on Medical Service.

Additionally, in reporting services, physicians should always use the exact terminology for the service rendered as it appears in the Blue Shield booklet titled "Procedure Terminology Manual With Procedure Codes" issued in 1966.

Failure to use the correct terminology could cause a clerk to pick out a procedure which *she* thinks is the one you performed. If the procedure performed is not listed in the terminology manual, the Medicare form should be marked "unlisted procedure—request referral to a doctor for coding."

These guidelines are the result of discussions with Blue Shield officials responsible for Medicare claims processing.

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brand of
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Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate) 50 mg. of phenylpropanolamine hydrochloride, 2.5 mg. of isopropamide, as the iodide

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.

Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake, discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness, excessive dryness of nose, throat or mouth, nervousness, insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.

Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

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when your patients need continuous potassium supplementation...

offer the unique choice of tangy lime, delicious orange

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each effervescent tablet contains 2.5 Gm. potassium bicarbonate (25 mEq. elemental potassium), 2.1 Gm. citric acid, and cyclamic acid

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With its two citrus flavors, K-Lyte offers really *special* taste appeal to assure long-term acceptance . . . patients will take the K-Lyte you prescribe.

Patients like the special convenience of K-Lyte. Each effervescent tablet dissolves quickly and completely in 3 to 4 ounces of cold water. Just two tablets daily provide 50 mEq. of elemental potassium to help prevent or correct potassium deficiency. K-Lyte is absorbed rapidly — and avoids any potential hazards of potassium chloride tablets.

to guide you in prescribing K-Lyte:

Composition: Each tablet contains potassium bicarbonate (2.5 Gm.), citric acid (2.1 Gm.), cyclamic acid, artificial flavor and color. **Contraindications:** When renal function is impaired, or if the patient has Addison's disease, potassium supplementation should not ordinarily be instituted. **Precautions:** Should not be used in patients with low urinary output unless under the supervision of a physician. In established hypokalemia, attention should be directed toward correction of frequently associated hypochloremic alkalosis and other potential electrolyte disturbances. Patients should be directed to dissolve tablet in stated amount of water to assure against gastrointestinal injury associated with the oral ingestion of concentrated potassium salt preparations. **Side Effects:** While nausea has been reported in an occasional patient, K-Lyte produces no serious side effects when given in recommended doses to patients with normal renal function and urinary output. Potassium intoxication causes listlessness, mental confusion, tingling of the extremities and other symptoms associated with a high concentration of potassium in the serum. **Administration and Dosage:** K-Lyte effervescent tablets must be dissolved in 3 to 4 ounces of water before taking. Adults: 1 tablet 2 to 4 times daily, depending on the requirements of the patient. Two tablets (50 mEq. of elemental potassium) supply the approximate normal adult daily requirement. **How Supplied:** Effervescent tablets — boxes of 30 (orange or lime).

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Education Awards Offered to MD's

Pennsylvania physicians received last month a brochure titled "The Physician's Recognition Award"—a detailing of information regarding the continuing education award program which was established at the AMA Clinical Convention in December, 1968.

The 1969 House of Delegates, in its October annual meeting, endorsed this program and recommended that each member of the Society strive for the award.

Application for the award is voluntary and any physician in any field of medicine may apply. Practicing physicians may qualify by reporting 150 credit hours of continuing education within the last three years (sixty hours of this time must be in a required-credit category.)

Required credit hours are given for any course sponsored by:

1. An AMA accredited education institution (note: The AMA code in the Continuing Education pages of PENNSYLVANIA MEDICINE indicates courses planned by those Pennsylvania institutions which have been accredited to date).
2. The Council on Education and Science of PMS (including the last four annual scientific seminars).
3. An institution listed in Continuing Education Courses for Physicians in JAMA (see Pages 759-763, August 4, 1969, edition JAMA).

Pennsylvania physicians can volunteer evidence now of continuing educational efforts that are insuring up-to-date medical care for the citizens of the Commonwealth by completing and returning the Credit Record which was mailed by the AMA last month.

PAGP Awards Presented

Milton Perloff, M.D., *second from right, president of the Philadelphia Academy of General Practice, and program chairman of the Third Annual J. Herbert Nagler Memorial Symposium held recently at the Holiday Inn, City Line, Philadelphia, presented awards at the symposium to Louis H. Weiner, M.D., seated left, first president of the Pennsylvania and Philadelphia Academies of General Practice; and Bernard B. Zamostien, M.D., standing right, current president of the Pennsylvania Academy of General Practice. Looking on is Edward Kowalewski, M.D., president of the American Academy of General Practice. The recipients were among thirteen past presidents of the Philadelphia Academy of General Practice who received plaques at the symposium for their service to the academy.*

Sewickley Valley to Educate Doctors

In keeping with the recent trend of presenting postgraduate courses at the community hospital level, Sewickley Valley Hospital, Sewickley, has embarked on a program of continuing education for physicians on its medical staff as well as for doctors from other hospitals in the surrounding areas.

The new approach has been found very successful in recent pilot programs sponsored by the Pennsylvania Medical Society and tentative association has been arranged with the Cleveland Clinic and Jefferson Medical College for the presentation of several postgraduate programs throughout the ensuing year.

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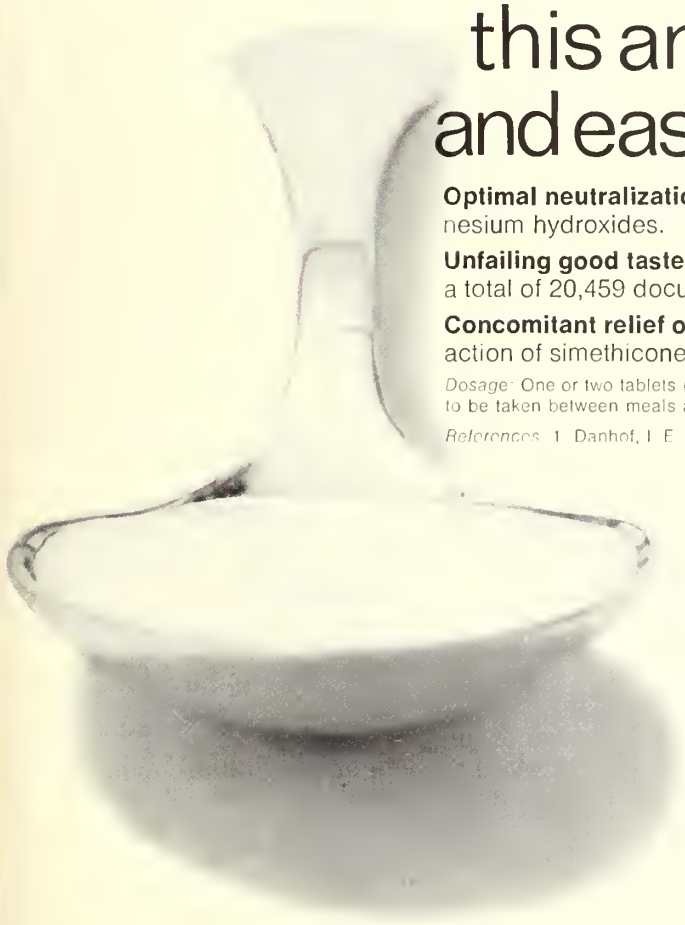
Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E. Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

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LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

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TV Executive Heads Health, Hospital Council

Officers were elected and the application of the Health and Hospital Planning Council of Northeastern Pennsylvania was approved by the state advisory council for comprehensive health planning at a meeting recently in Camp Hill.

Peter W. Duncan, editorial director, WCAU-TV, Philadelphia, was re-elected president of the Council and Richard D. Rife, president, Capital Blue Cross, Harrisburg, was reelected vice president. Both offices have one-year terms.

The Council recommended approval of the application of the Northeastern Pennsylvania Council for submission by the state secretary of health to the U.S. Public Health Service (USPHS). The group is seeking $43,891 to organize for comprehensive health planning.

In other business the state advisory council approved the application of the New York-Penn Health Planning Council, Inc., for $52,526 in continuation funds from USPHS. This group, which includes Bradford and Susquehanna Counties, in Pennsylvania and Tioga and Broome Counties in N.Y., had been funded the same amount in January for one year. USPHS grants are matched equally by contributions from local groups.

The chairmen of four task forces to the Advisory Council reported on their first meetings held in September. State Secretary of Community Affairs Joseph M. Barr, Jr., chairman of the Task Force on Planning Coordination, said the committee will inventory all agencies involved in some phase of health planning. "We want to see where there are overlaps in jurisdictions and functions," Secretary Barr said.

The advisory council formed an ad hoc committee to study the definition of a consumer. The federal law on comprehensive health planning requires a majority of the members of all advisory groups to be consumers of health services.

50-year Award Presented

Henry R. O'Brien, M.D., *second from left, of Camp Hill, recently was presented the PMS Fifty-year Award in recognition of his years of medical service. President-elect David A. Smith, M.D., of the Dauphin County Medical Society, second from right, made the presentation. Looking on are Mrs. O'Brien, left, and Albert L. Chapman, M.D., right. Dr. O'Brien received his medical degree in 1919 from the University of Michigan School of Medicine, and is certified by the American Board of Preventive Medicine. He retired from service with the Pennsylvania Department of Health in 1964.*

Staffing improved but below average

Anesthesiology Manpower Assessed

A survey of all hospitals in Pittsburgh and Allegheny County showed anesthesiologists not only administered anesthesia but were also actively involved in emergency service in 30 to 50 per cent, according to a report presented at the American Society of Anesthesiologists convention.

Although staffing by anesthesiologists has considerably improved in Allegheny County during the last decade it is still below the desired average of 1 per 1,000 anesthesias a year, said the authors, Peter Safar, M.D., and Donald M. Benson, M.D., of the Department of Anesthesiology, University of Pittsburgh, and Presbyterian-University Hospital.

A thirty-five page survey form was designed to combine an assessment of emergency medical facilities with a survey of anesthesiology manpower and anesthesiologists' extra-operating room involvement.

Hospitals were visited in May and June of this year for a half to one day each. Visits began with a conference with the administrator followed by a visit of the facilities, including emergency room, intensive coronary unit, coronary care unit, operating room suite, inhalation therapy, roentgenology and resuscitation services.

All hospitals had emergency rooms but only eleven had a registered nurse on duty twenty-four hours. All hospitals said they had some type of organized resuscitation coverage. Of the twenty-one hospitals on which data is available, in seven, anesthesiologists provided twenty-four-hour emergency room resuscitation service.

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2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
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6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

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Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
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INDICATIONS Advantage is taken of the anabolic action of ANDROID without its virilizing effect Estrogen balances the androgen—only steroid effect remains. Geriatrics, post operative and debilitating disease, osteoporosis **DOSE** One tablet t.i.d Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS.** In the female, excessive dosage may produce virilizing effects of most androgens hoarseness, hirsutism, enlarged clitoris Symptoms can be avoided by keeping the dosage below 300 mg of testosterone per month **CONTRAINDICATIONS** See Android Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands

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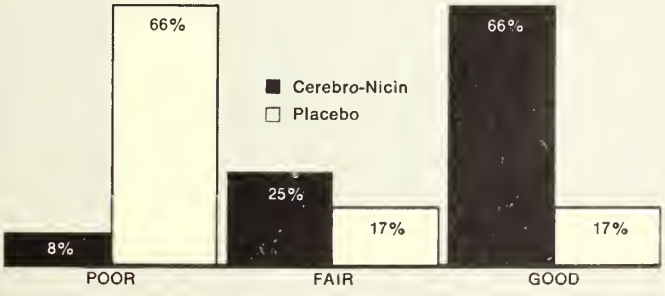

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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir 8 oz. bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

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PAMA Group Tours PMS

Lackawanna County *Pennsylvania Association of Medical Assistants (PAMA) representatives visited PMS Headquarters in Lemoyne last month as a climax to their tour of Pennsylvania Blue Shield offices. John F. Rineman, PMS executive director, welcomed Miss Jane McNulty (center), PAMA president-elect, and the group which took a moment out of their Society visit for a preview of a new advertisement about their organization appearing in* PENNSYLVANIA MEDICINE. *The medical assistants received a detailed claims processing orientation during their tour of Blue Shield facilities.*

PMS Official To Attend USP Decennial

George E. Farrar, Jr., M.D., immediate past president of the Pennsylvania Medical Society, will represent PMS at the decennial meeting of the United States Pharmacopeial Convention April 8-10, 1970 at the Shoreham Hotel, Washington, D. C.

On April 9, a special program will be presented honoring the 150th anniversary of the founding of The United States Pharmacopeia.

The second and final call for delegates to the decennial meeting was recently mailed to all organizations entitled to representation. The United States Pharmacopeia is the only national organization representing both the pharmacy and medical professions and its member organizations include state associations and societies of medicine and pharmacy, pharmacy and medical schools, various branches of the federal government, and national medical and pharmacy organizations.

Not only will this meeting be of special interest because of the sesquicentennial celebration, but it is expected that delegates will be giving new guidance and direction to U.S.P. programs.

PAMA Representative Certified, Honored

Miss Geraldine B. Shunkwiler of Paoli was one of ninety-nine medical assistants certified in 1969 and honored recently at the Thirteenth Annual Convention of the American Association of Medical Assistants. She was certified as both a clinical and an administrative assistant. Of those certified this year twenty-six had dual certification, thirty-eight earned clinical certification and thirty-five were certified as administrative assistants.

Miss Shunkwiler was the only Pennsylvanian to be certified in 1969.

Healthmobile Services Discussed

Discussing the operation *of Philadelphia's first Healthmobile, a unit to provide comprehensive health tests in areas of greatest need are (l. to r.) Edmund L. Housel, M.D., chairman of the United Health Services Education Council, responsible for planning the Healthmobile, William Spotwood, executive director of the Young Great Society's Medical Center, which will operate the unit, and George E. Farrar, Jr., M.D., president of United Health Services and PMS past president. United Health Services last year received $152,000 from the United Fund Torch Drive, and has allocated $35,000 to operate the Healthmobile for the first year.*

Malnutrition Target of AMA Magazine

A controversial issue—malnutrition in the United States—began being explored in depth in the September issue of *Today's Health,* the popular magazine published by the American Medical Association each month to inform the public of medical advances and health services.

Should we taxpayers spend billions of dollars to send men to the moon and sustain a major military establishment in Vietnam while American citizens on their home continent, in depressed areas, may be starving?

This is the question in ferment and of dissidence that these articles answer, pro and con, through interviews by authorities in the field of nutrition.

For example, the September report, "Finally, Facts on Malnutrition in the United States," quoted Sen. George McGovern, chairman of the Senate Select Committee on Nutrition and Human Needs, who had toured villages of migrant farm workers: "We have seen diet and living conditions that one might expect to find in Asia, not America. Most cattle and hogs in America are better fed . . ."

While acknowledging that the problem of malnutrition no doubt is widespread in low-income regions, Dr. Fredrick Stare of Harvard University told the House Committee on Education and Labor that the report of the Citizens' Board of Inquiry Into Hunger and Malnutrition, "Hunger U.S.A.," issued last April, was based more on opinion than fact. The report stated that 10,000,000 Americans are underfed or malnourished.

Dr. Stare told the congressmen that the report "is an attention-getting document which I assume it was intended to be. It is, however, based largely on testimony and opinion and not on facts as to the extent and severity of malnutrition."

His critique was that the report placed its emphasis on the absence of knowledge on malnutrition and hunger in this country.

In the October issue of *Today's Health,* an article on the "Faces of Hunger" tells of children in America dying from lack of food and/or proper, balanced diets. According to the report, the problem is not alone with rural migrants and share croppers; it is equally suffered by ghetto dwellers in the big cities: "The recipe (of malnutrition) has been passed down from generation to generation in the rat and roach-infested kitchens of city slums, the waterless kitchens of the rural South, the wood-burning kitchens of Appalachia, and the curtainless kitchens of migratory farm workers. . . . Malnutrition a' la America calls for poverty and ignorance—ignorance in budgeting money, ignorance in meal planning, and ignorance in food preparation.

While perhaps unpleasant subjects, the morality of a prosperous nation allowing—or ignoring—many citizens suffering diseases and perhaps death from malnutrition characterizes the forthrightness and topicality of the subjects reported in *Today's Health.* This series on malnutrition in America, for example, will continue for several monthly issues into the spring of 1970, featuring articles and editorials by top nutritionists and other authoritative observers of the social scene.

New center for brain-damaged children

Groundbreaking at Elwyn

Groundbreaking ceremonies took place recently at the site of the new Douglas T. Davidson Center for Brain Damaged Children at Elwyn Institute by Gerald R. Clark, M.D., president, and Mr. Wallace E. Frank, of Westtown, Pa., board chairman.

Scheduled for completion this year, the new center will enable Elwyn to continue its leadership in research and education of children with neurological impairments. Hundreds of children between the ages of six and eighteen suffering from brain damage will benefit through direct treatment at the center. Thousands of others will benefit by the fact that methods developed will be shared with schools and institutions in the United States and abroad.

According to Dr. Clark, the child with brain damage—or brain dysfunction—generally shows a short attention span, inability to conceptualize things as a whole, poor coordination of body muscles and hyperactivity. He adds that without the special education and treatment many would be unable to develop their potential and would require lifelong institutional care.

"Elwyn Institute decided to construct a center for brain damaged children because there is an extreme shortage of facilities for this purpose in the United States," said Mr. Frank. "The need has been underscored by many studies."

A recent report by Syracuse University showed that at least ten times the number of facilities currently available for minimally brain damaged children are needed in Pennsylvania.

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PENNSYLVANIA MEDICINE

close-up/MD's

Walter I. Buchert, M.D., medical director of the Geisinger Medical Center, Danville has been elected second vice-president of the American Association of Medical Clinics at the recent annual meeting in New York City. As an officer, he will remain a member of the Board of Trustees, a position he has held since September, 1967. Dr. Buchert also was named to the Board of Directors of the Research Foundation of the AAMC.

C. Everett Koop, M.D., surgeon-in-chief at The Children's Hospital of Philadelphia, attended the fifty-fifth annual Clinical Congress of the American College of Surgeons, held in San Francisco in October. On October 19 Dr. Koop moderated a panel at a meeting of the surgical section of the American Academy of Pediatrics in Chicago. The program is entitled "Care of the Critically Ill Infant."

J. Montgomery Deaver, M.D., has been elected to the Board of Trustees of Lankenau Hospital. He fills a vacancy created when longtime trustee Frederic C. Wheeler retired to emeritus status. Harry R. Neilson Jr., board president, in announcing Dr. Deaver's election, said: "No one has done more for Lankenau over the years than he has." He said that Dr. Deaver was serving as an individual and not as a member of the medical staff. Dr. Deaver, who is senior consultant in surgery, has a long association with Lankenau. He came to the hospital as an intern in 1928 after earning his M.D. degree at the University of Pennsylvania School of Medicine.

Edward L. Bortz, M.D., of Bala Cynwyd, senior consultant in medicine at Lankenau Hospital, has been named to the recently-created White House Conference on Food, Nutrition and Health. He will serve as a panel chairman in Section II, "Establishing Guidelines for the Nutrition of Vulnerable Groups." The Bortz panel will consider the nutritional problems of the aging. Dr. Bortz is a former president of the American Geriatric Society as well as a former president of the American Medical Association.

William Weiss, M.D., Philadelphia, visiting associate professor of preventive medicine, Woman's Medical College, delivered a paper on "Smoking and Hearing Loss" on November 11 at the American Public Health Association's annual meeting at the Sheraton Hotel in Philadelphia. Internationally known for his research in lung cancer, Dr. Weiss recently was awarded a World Health Organization Travel Fellowship last May. It was granted primarily for his twelve-year, in-depth study with **Katherine R. Sturgis, M.D.,** on her Philadelphia Pulmonary Neoplasm Research Project, considered one of the most extensive ever done on lung cancer.

Samuel P. Harbison, M.D., professor of surgery and associate dean of the University of Pittsburgh School of Medicine, is first vice president-elect of the American College of Surgeons. He was elected at that organization's annual meeting. Dr. Harbison has been affiliated with the University Health Center of Pittsburgh for more than twenty years and has been associate dean for the past six years. From 1963 to 1968, Dr. Harbison served as secretary of the American College of Surgeons.

During the meetings of the World Congresses of Neurological Sciences held in New York City, the International Society for Research in Stereoencephalotomy had its fourth symposium at which **Ernest A. Spiegel, M.D.,** Philadelphia, delivered the presidential address on "The Impact of Stereoencephalotomy on the Physiology of the Human Subcortex." On his retirement after eight years in office, he was presented a Festschrift edited by **H. T. Wycis, M.D.,** to which over twenty scientists from twelve countries had contributed. The society established an Ernest A. Spiegel Lecture to be given at its meetings and an E. A. Spiegel medal to be awarded to the invited lecturer. The first golden medal was presented to Dr. Spiegel by Prof. T. Riechert of Freiburg, Germany, in recognition not only of his address, but also of his scientific achievements.

Ernest D. Helmick, M.D., Harrisburg ophthalmologist, has been elected to the International Registry of Who's Who in Geneva, Switzerland by its board of trustees. Dr. Helmick received a plaque acknowledging his election "for prominence and personal achievement."

John S. Donaldson, M.D., Pittsburgh orthopedic surgeon, has joined the staff of the department of graduate medical education of the American Medical Association. He will survey graduate training programs in the western part of the United States.

Donald N. Medearis, M.D., Pittsburgh, has been appointed new dean of the University of Pittsburgh School of Medicine, after two committees spent a year and a half to find a replacement for Vice Chancellor for the Health Professions F. Sargent Cheever, M.D., who had served as dean.

Edward Gorman, M.D., Philadelphia, a specialist in child and adolescent psychiatry, has been added to the medical staff of Friends Hospital. A member of the Charles Pebcrdy, Jr. Child Psychiatry Clinic at Hahnemann Medical College and Hospital, he will assist in the development of a coordinated adolescent program at the hospital.

Peter H. Berman, M.D., has been appointed director of pediatric neurology at The Children's Hospital of Philadelphia, **Alfred M. Bongiovanni, M.D.,** physician-in-chief, announced. Dr. Berman has also been named associate professor of pediatrics at the University of Pennsylvania School of Medicine by Dr. Bongiovanni, who is professor and chairman of the department of pediatrics at the university. In addition, Dr. Berman will hold the position of associate professor in the university's department of neurology, under the chairmanship of **Lewis P. Rowland, M.D.**

Max L. Ronis, M.D., has been named professor and chairman of otorhinology at Temple University School of Medicine, succeeding his father, **Bernard J. Ronis, M.D.,** who has given up his administrative duties to devote more time to teaching, research and private practice.

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close-up/MD's

Africa is My Home

By Ann K. Monteith

More at home now in his adopted land than in his native Pennsylvania Dutch country, Dr. Earl Reber, physician, research scientist, unofficial ambassador, and humanitarian, is bringing the benefits of modern medicine to Africa.

Dr. Earl Reber, the research scientist, studies a malaria positive blood smear in his laboratory.

In September, 1946, a young physician appeared at the Liberian Government Hospital in Monrovia for examination for certificate from the Liberian Medical Board. The young man was Earl Wayne Reber, M.D., a recent graduate of the Temple University School of Medicine, Philadelphia.

"He appeared a bit timid at first," notes Dr. J. N. Togba, then Director General of the National Public Health Service, "but upon examining several patients and after questioning, he regained self-confidence and made correct answers and diagnoses." The medical board became satisfied and awarded him the necessary certificate and permit to practice the medical profession in Liberia. Today, Dr. Earl Reber is acting resident director of the Liberian Institute of Tropical Medicine, a medical research facility operated by the American Foundation for Tropical Medicine.

Earl Reber's interest in medicine began during his high school days in Lebanon, Pennsylvania. "I knew I wanted to enter some type of medical service which did away with the profit motive," he says, "but my high school

(Continued on page 25)

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Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

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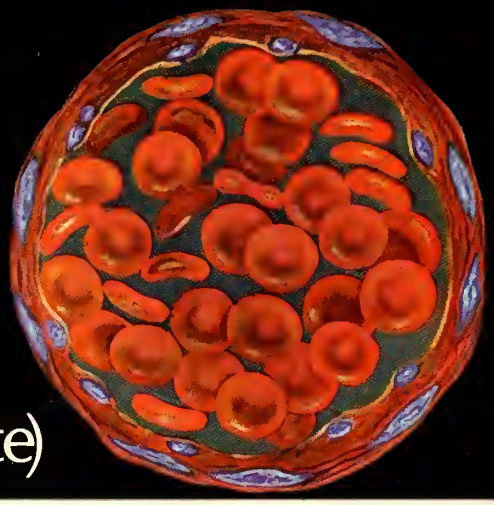

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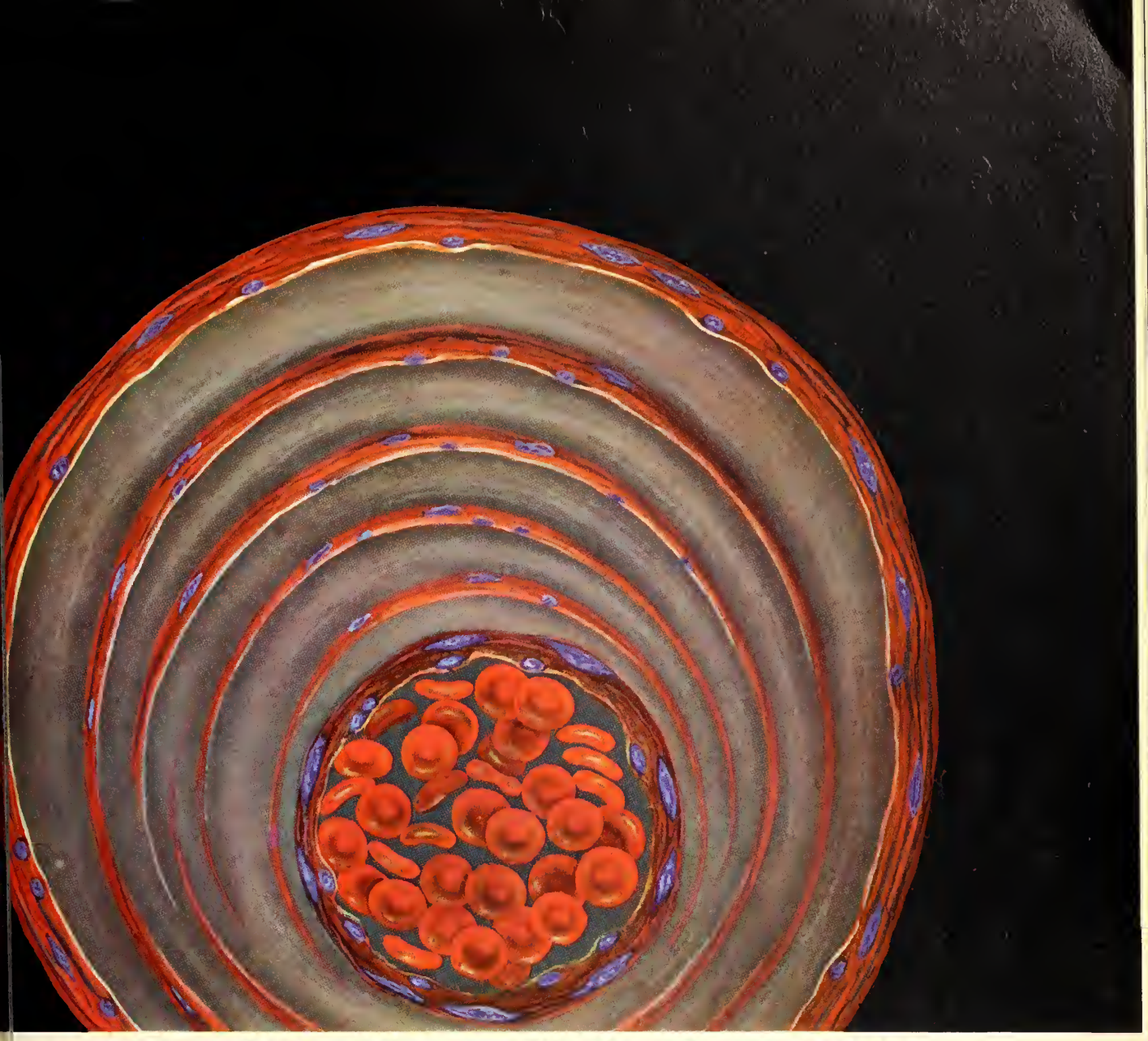

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A Liberian woman suffering from an enlarged and fibrous liver and spleen is examined by Dr. Reber.

grades didn't offer too much encouragement." The funds which he earned as an office boy at the Lebanon Steel Foundry from 1936-1939, plus scholarships, assistantships, and a considerable amount of mental diligence enabled Reber to graduate from Lebanon Valley College in the spring of 1942. During that summer, he worked at New Cumberland, thirty miles from Lebanon, doing labor.

"My classmate, Roger Morey, and I motored there most every day," he relates. "Sometimes I slept in boxcars because I was too tired to get home. One professional hobo helped me find better accommodations in passenger cars of the 'Pennsy.' He also told me how to get a free ride on the Pennsy Harrisburg to Philadelphia run on which he had commuted quite regularly over the years.

"Roger Morey," he continues, "worked himself up to the exalted position of timekeeper—I became a leader of men. Seven Negroes and I were given timber hooks—one man on each side—so I had to carry my part of the load and lead the crew to the area where the timber was to be placed. I found it a wonderful opportunity to learn something about the Negro. Their senses of humor were excellent and they overlooked the fact that my end of the load often dragged a bit. It made them laugh to see a man with his college degree confined to the weight lifting role—a role in which they reigned supreme because of their brawn. What really stood out, though, is how quickly they accepted me and how I became a part of their humor and delivery."

Once in medical school, Earl Reber's future career again was threatened by lack of funds. Through associates of his aunt, then a missionary under the Lutheran Church in Liberia, Reber was able to secure financial assistance from the Board of Foreign Missions of the United Lutheran Church and received the M.D. degree from Temple in 1945. Following the completion of his internship in 1946, Dr. Reber served the church as a medical missionary in Liberia until 1962, when he became affiliated with the Liberian Institute of Tropical Medicine.

Earl Reber and his wife, the former Anna Mae Bomberger came to Liberia when the need for medical services was acute due to the fact that there had been no doctor in the field during the years of World War II. The Lutheran Mission assigned him to ZorZor, Western Province, near the Guinea border. Road building was just beginning, so equipment and supplies had to be transported 200 miles from the coast to ZorZor over rough jungle footpaths.

No other medical services existed in this area of the interior, and the entire Lutheran medical mission had to be reconstructed—a task which included moving the Phebe School of Nursing to ZorZor. The young doctor met little staff, fewer supplies, little budget, and a community with monumental health problems: high infant and maternal morbidity and mortality, a variety of tropical and communicable diseases, and a multitude of medical, surgical, pediatric, and obstetrical emergencies. He helped to teach nurses, medical assistants, and midwives, always managing well to have on hand needed supplies and medicines. He saw to it that electricity was installed, and many times his co-workers found their director laying pipe for new water systems.

"I did plumbing, electricity, and building," notes Reber, "because using my hands helped to get the bugs out of my brain when the patient load was just too much for me to handle and to concentrate upon hour in and hour out. Father taught me plumbing and electricity for practical reasons, but it became my relaxation."

Thousands of Liberians began to benefit from the care and concern of the American doctor. The patient record system which he devised provided epidemiological information useful in health planning, and health programs which he established through the schools made periodic physical examinations available for students. His well baby clinic usually accommodated from 200 to 300 babies a day, but a former clinic nurse recalls that on one extraordinary day, Dr. Reber treated 600 infants.

"The Day of 600 Babies just about destroyed my love for infants," he remembers. "With half of them crying and all of the mothers talking, one had a ringing in the ears not unlike military jets without their sound suppressors."

Each year Dr. Reber expanded medical services. He began programs of family planning, smallpox vaccinations, DPT immunization, and tuberculosis skin testing. He established a leper colony and helped to change community attitudes toward acceptance and rehabilitation of leprosy patients. Families who once brought tuberculosis patients to the clinics only when they were near death, began to bring them for treatment early enough to effect recovery. His persuasion helped the community to accept blood transfusions useful in lowering maternal and infant mortality rates. Through his work with health educators, the people began to understand how diarrhea, hookworm, tetanus, malaria, and malnutrition could be prevented. Liberian President W.V.S. Tubman officially recognized the doctor's dedication to the Lutheran Mission in 1949 when

he decorated him with the Star of Africa, Officer Rank, given specifically for his efforts in developing a simple way to skin graft tropical ulcers.

Realizing the need for expanded public health services in Liberia, Reber left his post in 1949 for a year of pathology residency at Philadelphia's Episcopal Hospital and to earn the M.P.H. degree from the Johns Hopkins School of Public Health during 1950 and 1951. Upon his return to Liberia, he made valuable contributions toward malaria control, sleeping sickness surveillance, and improvement of environmental sanitation conditions.

In 1954 Dr. Reber returned to Episcopal Hospital for a second year's residency in pathology, and in 1960 and 1961 he did research in tropical medicine at the Columbia University School of Public Health. His work at Columbia rekindled a love for research which he says began at Lebanon Valley College. "My interest in tropical medicine research continued while I was at ZorZor, so when the Phebe Hospital was moved to Suakoko in 1963, I came to the Liberian Institute of Tropical Medicine as a research scientist and clinician. When Dr. Reinhard Hoeppli, the institute's director, retired in 1964, I was made acting resident director."

The Liberian Institute of Tropical Medicine is located in Harbel, fifty miles from the capital city of Monrovia, and less than a half mile from the Farmington River where the doctor likes to fish. Nearby, at a bay of the Farmington River is a point labeled SNAFU where today rest the rusting hulks of World War II landing craft. The Reber's house is in direct line with the runway of Roberts Field International Airport, located just three miles away, and according to Dr. Reber "the Pan Am jets are so often right on schedule we can set our watches by them."

Lab technician Joseph Davis performs a hookworm egg count as part of the hookworm infection evaluation program for children.

It is this proximity to Roberts Field that involved Dr. Reber in an event which had a significant impact on his life. In the early morning hours of Sunday, April 2, 1967, a Varig Airline plane crashed less than a mile from the Reber home on its final approach to Roberts Field. Dr. Reber was called immediately. He treated the injured brought to his clinic, then began the grim job of removing the cremated bodies from the plane. "As acting government pathologist, the removal of bodies was my responsibility," Reber notes. "By nightfall we removed fifty-one bodies, most completely cremated beyond recognition, and stored them at the institute. We worked Monday and Tuesday trying to identify and catalogue identifying items such as bridgework and dentures. Only thirteen were identified. All were sealed in drums and I spent several hours welding to help get the remains to Brazil by Friday." After the accident, Dr. Reber served as chairman of the human factors committee for the board of inquiry of the Liberian Government and was commended by Erik de Carvalho, president of Varig Airlines, for his efforts.

Located five miles away from the Institute is the 90,000-acre Firestone Rubber Plantation, the United States' chief supplier of liquid latex, and it is in memory of Harvey Firestone that the institute's well-equipped buildings were constructed. The main building consists of two wings which house laboratories and offices for scientists. The laboratories can accommodate eight scientists as well as a number of technicians. "The labs are fairly well-equipped," notes the doctor. "They include balances, microscopes, microtomes, electrophoresis apparatus, and other specialized instruments necessary for research in tropical medicine. As far as housing is concerned, it is similar to the type found on the Firestone Plantation and is quite fine. Houses are made of brick and are air-conditioned. Some of the units are built on top of pillars and benefit from a fine breeze."

Dr. and Mrs. Reber find their life

Built in memory of Harvey Firestone, the well-constructed main building of the Liberian Institute of Tropical Medicine was turned over to the American

at Harbel to be quite comfortable in spite of the demands which the institute makes upon his time. Mrs. Reber, too, has been active in Liberian community life. During Dr. Reber's years at ZorZor, she taught English, psychology, and mathematics until the schools were turned over to the nationals of the church. At the Phebe Hospital she took charge of bookkeeping and now helps with accounts at the institute. Until her mother's illness forced Mrs. Reber to return to the United States several months ago, she had served as principal of the Farmington Community School, a school for both expatriate and Liberian children. Her spare moments have been occupied with church work, teaching piano, entertaining visiting scientists and doctors, playing the organ in church, accompanying the local Firestone Singers, and recently Mrs. Reber has become interested in amateur theatrics. "Anna Mae played in *Arsenic and Old Lace* and was quite well-received," notes her husband. "I thought for a while that I was going to lose my wife to Broadway, but luckily she has decided to stick on."

As head of the institute, most of Dr. Reber's days are occupied with administrative and clinical matters, but each Tuesday he escapes his usual routine to make the fifty-mile car trip into Monrovia to attend to the many details connected with his work in Liberia. The business which he conducts in town often ranges from collecting subsidy money paid to the institute by the Liberian government, to picking up the week's newspapers, purchasing food for laboratory rats and mice, and attending to the procedures which allow visiting scientists and doctors to enter and leave the country.

Dr. Reber usually visits local drug stores on his Tuesday excursions. Here he advises the proprietors about how to prevent importation of drugs that are below standard. "It is very com-

Foundation for Tropical Medicine in 1951 by the Firestone Rubber Plantation.

mon knowledge," Reber states, "that some drug firms, even some in the U.S., will export drugs that are not of the same quality as those used in home trade. I learned this early as a missionary when I found that I could get only 7 cc of penicillin out of a 10 cc bottle. Some of the drugs we receive are mislabeled. One cure-all which could not stand up to standards set by the Food and Drug Administration, for example, was labeled in an inconspicious spot 'made for export only.' I try to help the druggists prevent this kind of thing without getting them involved in a bureau of standards that would be very expensive to run."

Since there is no telephone service between Monrovia and the institute, each Tuesday it is the doctor's practice to stop at the Central Laboratory of the National Public Health Service where citizens and physicians can call to find out if he is in town and to leave word about meetings of interest.

Many times his assistance is sought on matters concerning the Liberian Medical Association, an organization which he helped to establish and which now enjoys a paying membership of eighty physicians. In 1966 the members of the Association elected the American doctor to a one-year term as their president. Dr. Reber was the first non-Liberian so honored, and at present he serves as editor of the *Journal of the Liberian Medical Association.*

Since there are few veterinarians in Liberia, Dr. Reber sometimes is called upon to fill another void during his Tuesday trips by giving rabies and distemper shots to pets in Monrovia. "There are a good many dogs around the institute that need looking after as well as pets in town," he indicates. "I don't like to destroy animals, and I guess you can attribute my love for them to the fact that Anna Mae and I have a ten-year-old cat that owns us. Every night he curls up on my feet and goes to sleep, and each morning he wakes me up around half-past five so that I can do something about his food dish." The part-time veterinarian's pet care program has included immunization, surgery, and even setting broken limbs.

In 1965 the Temple University Medical Alumni Association honored Earl Reber as "medical alumnus of the year." In accepting the award in Philadelphia (the trip was made possible by his classmates) he spoke of the vast creative opportunity for those who work in Liberia. "This is especially true for one coming from the U.S.," he indicates. "No matter what kind of work you do here, you can see the fruits of your involvement in the increasing performance of your African staff.

"Part of the creative experience is just being a white person in a Negro republic. Working side by side with the people as equals is the best way to have them understand us and for us to learn of their problems too. When an event such as the death of Martin Luther King occurs it is a good thing that we can discuss the problem openly and straightforwardly with our Liberian friends. Africa no longer exists in a vacuum. The people are getting world news by their radios and so there is even a greater need for people of other countries and races to live here and to help them understand the news. The expatriate who makes a country such as Liberia his home is in a very good position to create better relationships between races and to establish an atmosphere of understanding."

As the occasions arise, Dr. Reber will leave medical duties to help his staff to interpret events which have occurred in the United States as well as those which have taken place in their own country. "Democratic processes are something new to the tribal people," he notes, "and they need help in understanding governmental operations such as taxation. Our missionaries, research workers, rubber planters, fruit companies, government officials, and other expatriates do a fine job in helping Liberians understand their own country."

Two years ago Dr. Reber worked in the schools trying to develop a drug suppressive for malaria, and he hopes to continue this work in the future. "This is the type of thing I like to do," he says. "I still have a little bit of the missionary complex, and I enjoy going out into the schools and working with the children and teachers. The malaria problem here is different from what one would find in Vietnam where malaria parasites have developed resistance to various drugs, because most of the drugs used in malaria studies here are active in the semi-immune populations of the schools." Reber eventually hopes to engage in research to determine the cause of drug resistance development in malaria parasites, as well as to find a way to lower costs of malaria suppression programs in the schools, and establish new medical training programs at the institute.

But all of Dr. Reber's plans for the future are tempered by the knowledge that the institute continues to operate within a hair's breadth of bankruptcy. "The reason," he says, "is that in spite of the fact that the United States is fighting a war in Vietnam, there is a fading interest in research in tropical diseases. A great deal of the research on drugs to combat tropical diseases is coming out of Europe rather than from the U.S.

At the June, 1967, commencement of Lebanon Valley College, this doctor to so many was honored with the honorary degree of Doctor of Science. "Returning to Lebanon Valley to accept this great honor brought a strange realization to me," he related. "It was quite startling for me to recognize that the place I originally came from is probably as strange as a foreign country. Liberia has become the place where I have my friends and where my wife and I know the way of life and find it comfortable. Yes, Liberia *is* my home."

Reprinted from The Review, Lebanon Valley College. Photos by Dr. William Sodeman, Liberian Institute of Tropical Medicine.

Techician Jacob Morris prepares field snails which will be used in research in schistosomiasis parasite disease.

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Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

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Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

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close-up/MD's

WELCOME, NEW MEMBERS!

These MD's have joined the State Society in recent months:

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BERKS COUNTY:

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BLAIR COUNTY:

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Paul P. Bricknell, M.D., 1219 Thirteenth Ave., Altoona 16601.

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BRADFORD COUNTY:

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LEHIGH COUNTY:

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John J. Schoff, M.D., Norristown State Hospital, Norristown 19401.

Jeffery R. Weiner, M.D., Highland Ave. and Keith Rd., Abington 19001.

Norman M. Werther, M.D., Highland Ave. and Keith Rd., Abington 19001.

Melvin Yudis, M.D., 7901 Henry Ave., C-309, Philadelphia 19128.

PHILADELPHIA COUNTY:

Brigida DeGuzman, M.D., 3700 Baring St., Philadelphia 19104.

Roger E. Linneman, M.D., 410 Wilford Bldg., Thirty-third and Arch Sts., Philadelphia 19104.

In the Commonwealth

Air Quality Standards Sent to HEW

Strong air quality standards setting strict limits on the amounts of sulfur dioxide and particulates—dust, soot and smoke—which may be emitted have been forwarded to the Department of Health, Education, and Welfare for approval after adoption by the Pennsylvania Air Pollution Commission. Upon approval by the HEW, an implementation plan for enforcement of the standards must be adopted by the Commonwealth within 180 days, or by May 7, 1970, according to a commission spokesman.

The standards finally adopted had the full endorsement of Governor Raymond P. Shafer, and were approved following two public hearings at which there was almost unanimous demand for stronger standards than had been presented originally by the Air Pollution Commission. The standards will be applied to the entire state, as well as to the two Federally designated metropolitan "air basin" areas of Philadelphia and Pittsburgh.

Interim emission standards, based on the use of the best available controls, will be developed until the final implementation plan, containing emission standards prescribing the maximum amount of particulates and sulfure dioxide permitted from various sources, is adopted.

The standards limit the annual average of particulates to 65 micrograms per cubic meter of "community" air and allow an annual concentration of no more than 0.02 parts per milligram (ppm) of sulfur dioxide, or 0.10 ppm in a twenty-four hour period. An "antidegradation policy" to preserve areas in which present air quality is significantly better than the established standards also was adopted. Under this proposal, air quality of such areas may not be lowered "unless it has been affirmatively demonstrated to the commission that such a change is justifiable as a result of necessary economic or social development and will not result in air pollution as defined by the State Air Pollution Control Act."

In addition to the strict limits in sulfur and particulates, the standards include limits for airborne concentrations of lead, beryllium sulfates, sulfuric acid mists, fluorides, nitrogen dioxide, hydrogen sulfide and carbon monoxide.

The standards originally adopted by the commission were above the federal maximums, and, according to testimony offered by experts, including representatives of medical societies, were above those at which illness could be caused, particularly in the elderly, the very young, and those with chronic lung disease.

In the Nation

"Medicredit" Proposal Offered by AMA

An American Medical Association spokesman outlined the AMA's voluntary national health insurance plan, "Medicredit", for consideration by the House Ways and Means Committee.

Russell B. Roth, M.D., speaker of the AMA's House of Delegates and a practicing physician in Erie, said the plan, which would be financed in part by federal income tax credits, is flexible and would assure all Americans—no matter how limited their financial resources—of adequate health care protection.

"Representing this country's physicians as we do," Dr. Roth said, "the AMA is on record in its belief that it is the basic right of every citizen to have available to him good health care.

"Today we want to put before this committee a plan which is universal in scope, voluntary in nature, and realistic in terms of total program cost."

He estimated the program would cost the federal government $8 billion to $9 billion a year, but about $3 billion a year of that would be offset by liquidation of the medicaid program. Medicare would continue.

"For those in low-income categories, this protection is theirs without expense or contribution on their part," Dr. Roth said. "For those with moderate and higher levels of income, Medicredit provides a system of cash incentives to enable them to protect themselves against major health care costs . . .

"It would give to persons who have purchased comprehensive health insurance the option of receiving a tax credit on their annual federal income tax return, a credit based on their tax liability. That is, a taxpayer could take as a credit against the amount of income tax owed to the federal government, all or part of their personal cost for comprehensive health coverage. Persons or families with a lower tax liability (usually reflecting lower income or more dependents and allowable expenses) would receive a greater tax credit. And those families in the lower 30 per cent income range, would, without cost to them, receive a certificate enabling them to purchase health coverage from qualified groups or plans."

Basic medical benefits of Medicredit would include:

—Up to 60 days of inpatient hospital services, including maternity services;

—All emergency room and outpatient services provided in the hospital;

—All physicians' services, whether performed in the hospital, home, office or elsewhere.

Supplemental benefits to basic coverage would also be eligible for tax credits.

Airs and Waters

Our nation, which was instituted at Philadelphia by the signing of the Declaration of Independence, has recently been given a new lease on life by another activity taken in the City of Brotherly Love.

On October 9, 1969, the City Council of Philadelphia passes an ordinance which was characterized by *The Philadelphia Inquirer* as "the toughest air control bill in the nation" and by *The Evening Bulletin* as "the strongest air pollution control bill in the country." Not only do these venerable newspapers agree but we suspect that there is *no* dissenting voice.

This ordinance does not guarantee our viability as a race any more than the signed Declaration could guarantee our independent existence. But both were firm and courageous beginnings and both were unanimously taken.

The details of the ordinance are interesting and well worth the attention of every citizen who hopes to continue to live and breathe. But our present interest lies in a larger sphere. The contamination of our environment is as intolerable as was our relationship with Great Britain in 1776, and it is not more likely to be ameliorated without a considerable shake-up in the course of our lives. Neither can it be done without the involvement of virtually all of our citizens.

It is for this reason that the action taken by the City Council of Philadelphia is so significant for each of us. We all share a tendency to try to carry out our lives on a "business as usual" basis. Moreover, we all hesitate to interfere in the private or business affairs of our neighbors. This is doubtless the explanation, and an adequate one, for the fact that we have allowed the quality of our environment to deteriorate to the extent that its ability to sustain the life of our race is in question.

The Philadelphia ordinance is concerned only with air pollution. While we are heartened by its force and decisiveness, we must also recognize that it is very limited. It is only a beginning. Many more kinds of air pollution exist than are being tackled. And water pollution is not here being considered; at the opposite corner of our Commonwealth lies Lake Erie, an outstanding example of our national capacity to foul our environment.

The contamination of our streams and lakes demands the same type of drastic action as does the pollution of the air. We cannot avoid the fact that agriculture and industry are prospering at the expense of our water courses and our lakes. To restore their natural purity will require drastic action equal to that initiated in Philadelphia. But this action is essential and it does not grow easier by being deferred.

But, we *have* taken the first and hardest step. We have begun with the air and can now extend our efforts more easily to the total environment, once we have agreed that "business as usual" is not possible if we are to have a clean environment. The future will not be characterized by smooth and easy progress. The controls must extend to every household, every community, and every state and to the nation. Indeed international joint effort is a recognized necessity. Vigilance must be perpetual and the effort universal and continuous.

The push for such a hard and long-lasting effort must come from all people in all organizations. But no citizen has a clearer view of the problem than the practicing physician. Each of us as doctors should grasp every opportunity to be an advocate for immediate improvement in regulations regarding our environment. Each of us should take every chance, great and small, to lend impetus to the move to clean up our surroundings and to make this the best of all possible worlds. It will take much time and effort and we can afford no delay.

CBL

Worth Repeating

In all, the Pennsylvania Medical Society is a wonderful organization—solid and enduring yet labile and quick to act. But it is doing only a small part of what I expect it will be called upon to do in the next few years.

Now we are in the midst of unprecedented change in our country, a change so rapid that some call it revolution. Although not limited to health care or medicine, there has been a most rapid and radical change.

The Pennsylvania Medical Society will . . . be the normal agent to carry out the discussions . . . which appear to be on the horizon. Let us strengthen and extend its capabilities to make it more effective. We can only keep our preeminence by meeting the needs of the people.

CBL

Excerpted from remarks made at the recent PMS Annual Session.

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Vitamin A Acid

Topical Treatment in Acne Vulgaris

GERD PLEWIG, M.D.
Philadelphia

Topical treatment is the most common means of controlling acne vulgaris. Ancient peeling remedies such as sulfur and resorcinol are in wide use.[1,2,3] Combinations of these with benzoyl peroxide are gaining popularity.[4] Though benzoyl peroxide is superior to the older treatments [5], cases of contact sensitization are being increasingly recognized.[6,7,8] Systemic antibiotics[9,10,11,12] and in females the "pill,"[13,14,15,16] are drugs reserved for more inflammatory and cystic cases.

Oral Vitamin A has long been used as an adjunct in the therapy of acne.[17,18,19,20] It is given in the hope of curtailing the hyperkeratosis[21,22,23,24] of the sebaceous follicles where acne begins. In non-toxic doses, most studies fail to demonstrate real effectiveness [25].

In the hope of delivering a high, yet safe dose to the target tissue, we have examined the topical effects of various forms of Vitamin A in the treatment of acne vulgaris.

The available compounds of Vitamin A differ in their terminal radicals: the alcohol, aldehyde and acid are probably physiologic metabolites; the acetate and palmitate (Aquasynth® A Capsules) esters are commercial variants. They differ markedly in their effect on human epidermis in terms of irritancy, so much so, that topically applied Aquasol® A or Aquasynth® A produce no demonstrable reaction whereas the acid is the most powerful as a peeling agent. It should be made clear though that the benefits of Vitamin A acid stem mainly from its deep peeling effect which has nothing to do with its physiologic function as a vitamin.

We were not the first to use Vitamin A acid topically. Years ago dermatologists abroad reported good results in preliminary studies in various hyperkeratotic disorders.[26] Recently Frost has obtained beneficial results in ichthyosiform dermatoses and psoriasis.[27]

Our studies document the superior efficacy of Vitamin A acid when compared to traditional remedies: sulfur-resorcinol, and the current favorite, benzoyl peroxide.

Comparative Studies

Two widely used topical remedies

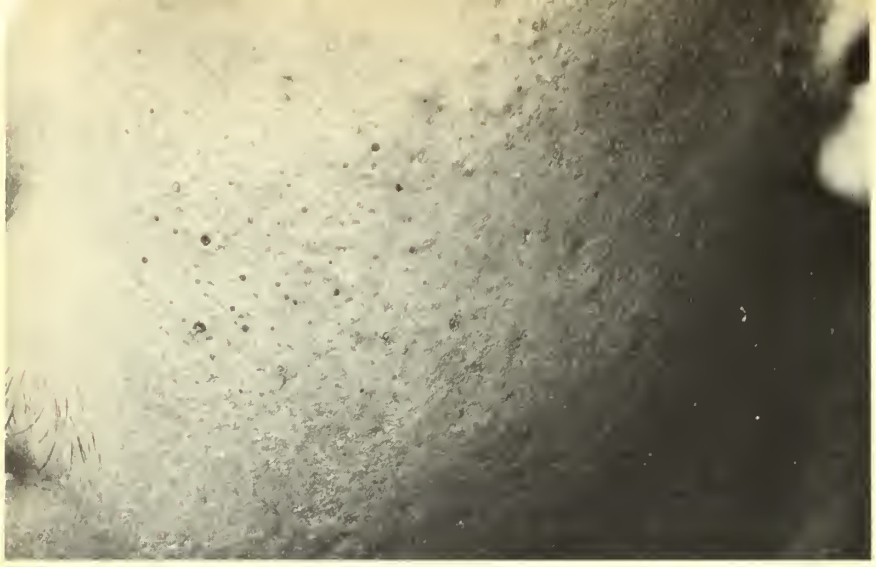
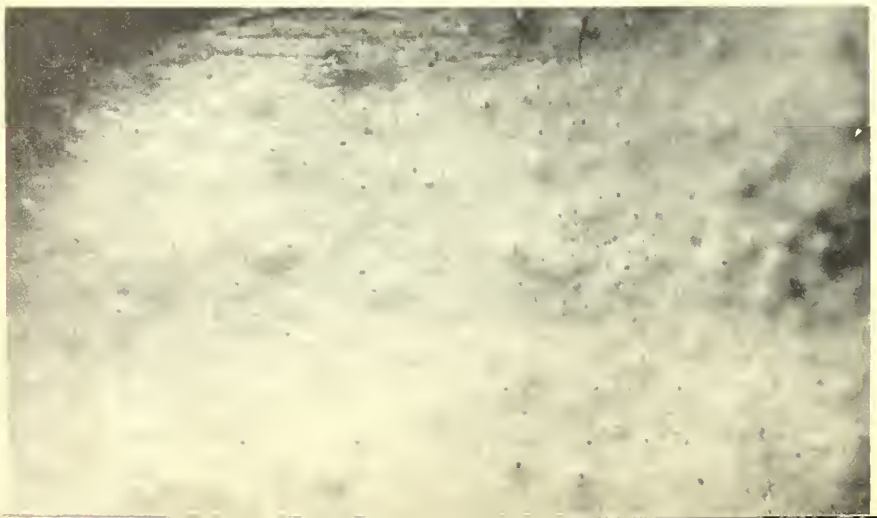


Figure 1: *Many blackheads (open comedones) and a few whiteheads (closed comedones; in right upper corner) in a 17 year old boy. No inflammatory lesions are present.*

Figure 2a: *Many closed comedones and two inflammatory papules in an 18 year old boy.*

Figure 2b: *Close-up picture of forehead from the same patient. Innumerous closed comedones, which show the minute openings, and a few open comedones.*



were compared in a clinical trial to Vitamin A acid in our acne clinic at the Hospital of the University of Pennsylvania; a benzoyl peroxide formulation (Vanoxide®) and a self-made shake lotion, which contained 5 per cent precipitated sulfur and 3 per cent resorcinol. Vitamin A acid was investigated as a .1 per cent solution w/v in equal parts of ethyl alcohol and propylene glycol. No concomitant acne surgery, local steroid injections, light treatment or systemic antibiotics were permitted. At weekly intervals all lesions on the left side of the face were counted using an accepted numerical system [10, 11]. The therapy was carried on for three to four months.

Results

The results are summarized in Table 1.

Drugs	Number of Patients	Decrease Mean Percentage
Sulfur-Resorcinol Lotion	37	15.9%
Vanoxide®	49	31.9%
Vitamin A acid	103	61.9%

Table 1: The mean percentage reduction in the count of all lesions from the left side of the face.

The sulfur resorcinol shake lotion was considerably less effective than Vanoxide,® but there is no doubt that Vitamin A acid is considerably more effective than all other tested regimens. This numerical appraisal largely reflects the efficacy of the agents in eliminating comedones.

Comments

Oral Vitamin A therapy was expected to reduce or prevent the hyperkeratosis in the pilosebaceous follicles. Topical Vitamin A acid (retinoic acid) was expected to exert the same effect of inhibiting keratinization. The contrary occurred, the irritation, caused by topical Vitamin A acid led to a swifter and increased production of horny cells. Histologic studies revealed an increased, not a decreased, proliferative activity manifested by thickening, parakeratosis and intercellular edema in the epithelial lining.[5, 28] There were qualitative changes as well. Instead of impacted cohesive layers of horny cells, which comprise the comedo, the cells became loose and the horny stuff easily sloughed. Apparently, the comedo, no longer firmly rooted, is pushed through

the orifice by the quickened stream of horny cells. This event of looser horny material seems to explain the benefits derived from topical Vitamin A acid treatment for acne lesions.

Acne vulgaris appears in a wide variety of clinical manifestations, which range from non-inflamed comedones (blackheads), closed comedones (whiteheads), to erythematous papules, pustules and deep destructive cysts. Any inflammatory lesion can lead towards scarring formation, which is the permanent hallmark of this disease.

Vitamin A acid promises to be extremely effective in the following types of acne vulgaris:

Blackheads: identical with open comedones (Fig. 1).

Whiteheads: identical with closed comedones (Fig. 2).

Comedo acne with erythematous papules and small pustules.

Recommended way of application:

The .1 per cent solution in equal parts of 95 per cent ethyl alcohol and propylene glycol is a slightly yellowish clear liquid. It is applied once a day with the tip of the finger to the entire face, sparing eyelids, nose and lips. The advantages of not leaving a greasy film and being colorless and invisible on the skin are obvious.

The medication should not be wiped or washed off. Vitamin A acid is a fairly potent irritant. Within forty-eight hours, the skin turns erythematous and stays that way as long as the treatment is continued. The patient should apply just enough to keep the face slightly red.

Some peeling and flaking occurs within the first three days, stays for several days and usually subsides completely during the following treatment phase. Vitamin A acid usually stings. The patients have to go through this uncomfortable period of stinging which lasts for about two weeks. All these effects are reversible: even after excessive use the skin recovers within a few days after stopping treatment.

We would like to illustrate two selected examples of acne which are best suitable for Vitamin A acid treatment.

Treatment of blackheads (open comedones, Fig. 1):

This variety of acne responds dramatically.

During the initial period of imflammation, open comedones, appear to rise up out of the skin, as if extruded

Blackheads respond dramatically

Generic and Trade Names of Drugs

Benzoyl peroxide	R — Vanoxide
	R — Benoxyl
Vitamin A alcohol	R — Aquasol A
Vitamin A Palmitate	R — Aquasynth A

by some propelling force. Within one to two weeks, comedones stud the surface and can be easily wiped off with the fingers; in most instances, they literally fall out of the skin. With no other preparations have we witnessed this phenomenon so vividly. This statement is true for facial comedones and those of the chest and back as well. Some of the comedones do not take this uneventful discharge. They turn into crops of small superficial pustules, which heal up completely without a scar. We have learned that these pustules originated from inflammatory explosions of pre-existing comedones.

Treatment of whiteheads (closed comedones, Fig. 2):

Closed comedones are known for their resistance to therapy.

Closed comedones are actually very difficult to squeeze out, even after prolonged facial steam baths. They are best demonstrated, when the skin is stretched between the fingers. During dermabrasion procedures, these hidden lesions are uncovered.

They are not only resistant to therapy, but at the same time notorious trouble makers. They explode like time bombs and lead to inflammatory papules and even cysts in the face, below the mandibular neckline and on the trunk. Patients in older age groups are especially plagued.

We like to see these patients, since we are fairly certain that within three to four months, most whiteheads will have been eliminated and inflammatory explosions prevented. Vitamin A acid is in our experience the treatment of choice for this type of acne.

Open comedones, in the acne eruptive age group of teenagers, may reappear. Palliative treatment is necessary with application every day to prevent new lesions. In many patients, however, comedones disappear forever once they have been removed with Vitamin A acid. We have observed patients up to two years who did not redevelop any new lesions and who had no follow-up treatment after the initial phase.

No scars were ever noticed, not even after the conversion of closed comedones into inflammatory lesions. No signs of systemic toxicity could be detected and not one case of contact allergy has yet been encountered.

Appraisal of new drugs require patience by patients and physicians. We would have missed the benefit of Vitamin A acid for closed comedones for instance, by just observing this drug for four to six weeks, when the great improvement does not come until six weeks.

Summary

Vitamin A acid topically was compared in a clinical study to sulfur-resorcinol and benzoyl peroxide. The method of appraisal was that of counting all the lesions on one side of the face at weekly intervals. Vitamin A acid was found to be superior to sulfur-resorcinol and benzoyl peroxide.

The effects of Vitamin A acid as a peeling agent on the epidermis and the comedo-structures were discussed. The production of loose horny cells, and not the prevention of hyperkeratinisation, prevented the formation of comedones and unseated existing ones. It is a palliative, not a curative treatment.

Clinical reactions to Vitamin A acid application are described. Two selected examples of acne, which are best suitable for this treatment were illustrated.

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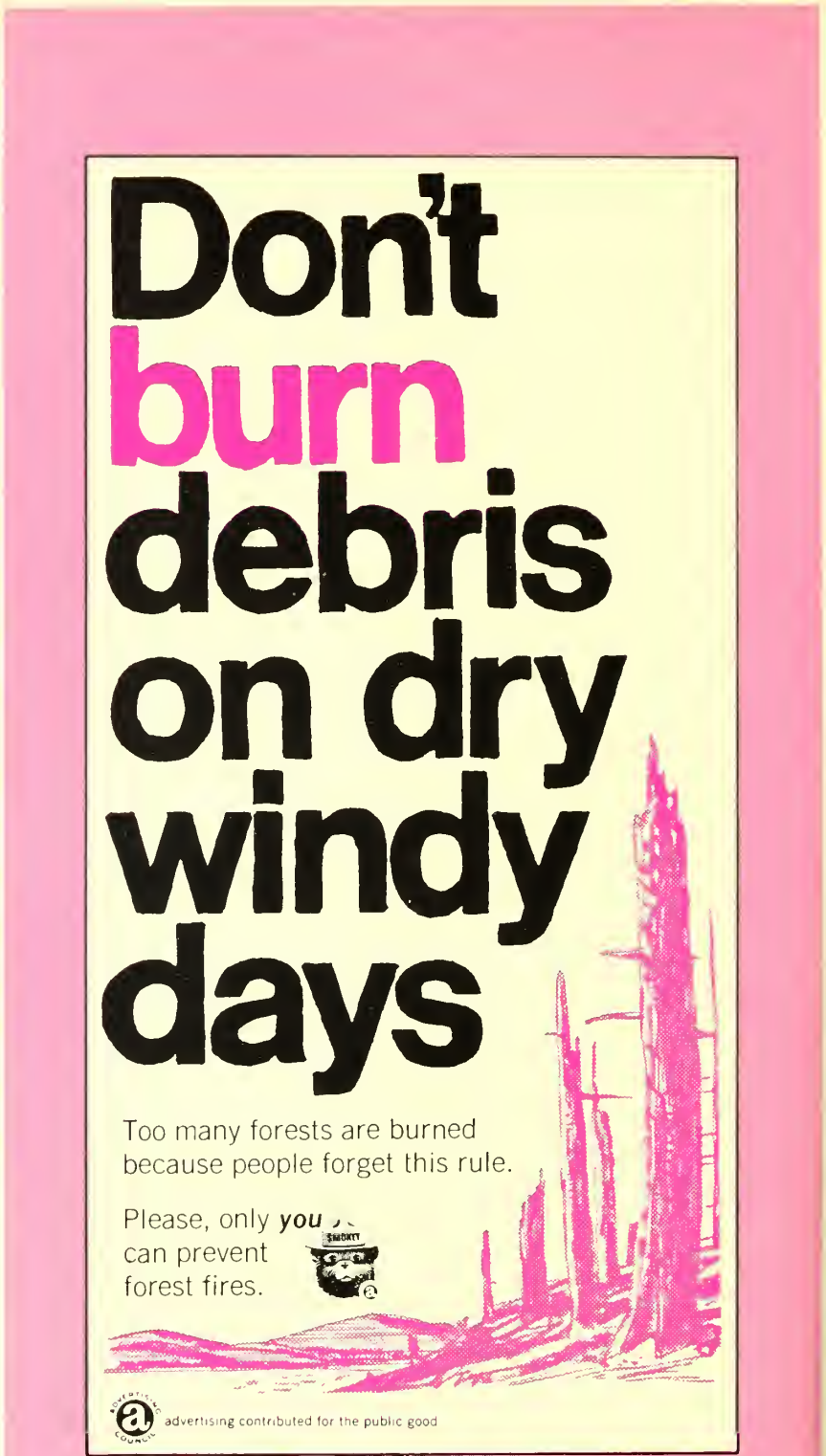

A new paramedical specialty

Inhalation Therapy

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"My reader will not wonder that, having ascertained the superior goodness of dephlogisticated air by mice living in it, and the other tests mentioned above, I should have the curiosity to taste it myself. . . . I have gratified that curiosity by breathing it, drawing it through a glass siphon, and by this means I reduced a large jar full of it to the standard of common air . . . but I fancied that my breath felt peculiarly light and easy for some time afterwards. Who can tell but that in time this pure air may become a fashionable article of luxury. Hirtherto, only two mice and myself have had the privilege of breathing it." Those were the remarks of Joseph Priestley when he discovered oxygen in the year 1774. It is now approximately 194 years since this great discovery and time certainly has proven oxygen an article of luxury.

Between 1775 and 1794 the fundamental principles of breathing were laid down by a French scientist Lavoisier. In the year 1880, Thomas Beddoes established a Pneumatic Institute at Bristol for the treatment of patients with heart disease and asthma, making use of face-pieces of oiled silk to contain oxygen. Many years have lapsed since the discovery of oxygen which has brought us to the present trend in the uses and the administration of such medicinal gases as oxygen, carbon dioxide, and helium. This brings us to the new and rapidly expanding para-medical specialty of inhalation therapy and its professional organization, The American Association for Inhalation Therapy. Inhalation therapy plays a vital role in the management of patients afflicted with cardio-pulmonary ailments and chronic pulmonary diseases, such as silicosis, asthma, chronic bronchitis, and emphysema. It is also used in the post-operative care of patients who have had upper and lower abdominal surgery, thoracic surgery, and orthopedic surgery.

Inhalation therapy involves the use of various types of equipment such as intermittent positive pressure breathing devices, more commonly known as IPPB/I, various types of nebulizers, from the bubble type to the most recent development, the ultrasonic nebulizer. Inhalation therapy departments are usually under the direction of an anesthesiologist or a chest physician, the department consists of a chief therapist and a varied number of assistants who have had some type of formal training.

The inhalation therapist or technician is a member of the American Association for Inhalation Therapy which was organized in 1956, and since has grown to a total of 5,500 members. To become eligible for membership, the applicant must have had one and one-half years' experience in inhalation therapy in a recognized institution or organization, and provided his primary function is directly related to patient care under medical supervision. The applicant must be of high moral character and conduct himself in a professional, ethical manner, he must be a high school graduate or have evidence of equivalent or higher education. Applicants are carefully investigated on a local and national level to be sure they meet these standards before being approved for membership.

The American Association for Inhalation Therapy is sponsored by the American College of Chest Physicians and the American Society of Anesthesiologists. These sponsoring organizations together with the American College of Allergists, American Thoracic Society, and American Association of Thoracic Surgeons provide a sixteen member board of medical advisors. The members of these organizations have made countless contributions to the organization and support of the American Association for Inhalation Therapy.

With the approval of the December, 1962 House of Delegates of the American Medical Association, the Board of Schools of Inhalation Therapy was organized under the Council on Medical Education and Hospitals. The board consists of seven members representing the sponsoring organizations—two physicians each from the American Society of Anesthesiologists and American College of Chest Physicians, and three registered therapists from the AAIT. The objective of the board of schools is to collaborate with the Council on Medical Educations of the AMA in implementing the "essentials of an acceptable school for inhalation therapy technicians as passed by the House of Delegates of the AMA. The board accomplishes this by receiving, and investigating applications and making recommendations to the Council on Medical Education of the AMA regarding the approval of schools.

The Council on Medical Education approves schools. The state of Pennsylvania has at present three approved schools. In the Philadelphia area there is the University of Pennsylvania, which offers a twenty-four month course leading to an associate degree. Located in the western part of the state is the University of Pittsburgh and in the southeastern part in Lancaster, is St. Joseph Hospital. Application for these schools can be obtained by writing to: Director, School of Inhalation Therapy at any of the above mentioned schools. The state of Pennsylvania has at present three chapters chartered by the American Association for Inhalation Therapy. They are the Delaware Valley Chapter, Central Pennsylvania Chapter, and the Greater Pittsburgh Chapter. Their purpose is to uphold the dignity and ethics of the inhalation therapy profession and to bring into one organization the inhalation therapists employed and/or residing within each chapter's geographical boundary so that, by frequent, full and frank interchange of thought, experience and opinions, inhalation therapy knowledge and progress may be extended, so that the profession may become more useful to the public in prolonging and adding comfort to life.

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Look around at the favorable publicity county medical societies received last year simply for presenting Benjamin Rush Awards.

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If you want an attention getter for your county medical society, plan your Rush Award program early. Send a post card to the PMS Council on Public Service for a comprehensive program kit.

REMINDER

BE SURE TO NOMINATE YOUR COUNTY BENJAMIN RUSH WINNERS FOR THE 1970 STATE COMPETITION

ENTRY DEADLINE

FEBRUARY 1, 1970

SEND YOUR NOMINATIONS TO THE PMS COUNCIL ON PUBLIC SERVICE

Until recently when interactions between drugs were considered, the problems involved usually were associated with the physical mixing of drugs. However, during the past several years there has been an increasing awareness of a more subtle type of interaction, that arising when one drug alters the expected therapeutic response to another drug that has been administered simultaneously. Although there have been many reports and reviews (1-10) of these interactions, knowledge in this area is expanding rapidly and should be continually brought to the attention of members of the health team.

There have been a number of mechanisms suggested as possible causes for these interactions and some of these are discussed below.

Possible Mechanisms of Drug Interactions

1. *Alteration of Gastrointestinal Absorption*

(a) Alteration of pH — Since many drugs are weak acids or weak bases, the pH of the gastrointestinal tract (GIT) will influence the site at which absorption takes place and the extent of absorption. It is recognized that the nonionized form of a drug will be more readily absorbed than the ionized form. Therefore, acidic drugs like aspirin and phenobarbital will be more readily absorbed from the stomach (having a lower pH) where they primarily exist in a nonionized form. If a drug such as an antacid is given that will raise the pH of the stomach contents it is possible that the absorption of such acidic drugs can be delayed and/or partially inhibited.

(b) Complexation—The interaction between tetracycline derivatives and certain metal ions is well known. Tetracycline can combine with metal ions such as calcium or aluminum in the GIT to form complexes that are poorly absorbed. Thus, the administration of certain dietary items (milk containing calcium) or drugs (antacids containing aluminum salts) to patients on tetracycline therapy could cause a significant decrease in the amount of tetracycline absorbed. It should be noted that in some instances a physician may suggest that milk be used when taking these drugs to help avoid gastrointestinal side effects that frequently accompany their use. In these situations he may be willing to sacrifice some of the drug's activity in order to have it better tolerated.

Other interactions involving complexation might be anticipated when the drug cholestyramine (Cuemid, Questran) is used. Cholestyramine is a high molecular weight resin that is used to complex with bile acids in the GIT, thus preventing their reabsorption. Because cholestyramine could complex with other medications given orally, thus preventing their absorption, it is recommended that it be given at least several hours after the administration of other drugs.

2. *Stimulation of Enzyme Systems*

It has been demonstrated by many investigators that phenobarbital can stimulate or increase the activity of liver microsomal enzymes. These enzymes are involved in the metabolism of many drugs. For example, it has been shown that the rate of metabolism of coumarin anticoagulants is increased in patients also being treated with phenobarbital (11). The result of this interaction would be a decreased response to the anticoagulant since it is being more rapidly metabolized and excreted. Therefore, to compensate for this loss of effect, the dose of the anticoagulant would have to be increased until the desired activity was obtained. A potentially dangerous situation could arise if the patient were

Drug Interactions

to discontinue taking the phenobarbital and the dose of the anticoagulant was not correspondingly reduced.

Many drugs, including other barbiturates, aminopyrine, phenylbutazone, and meprobamate have been shown to stimulate certain liver microsomal enzymes that are involved in drug metabolism. The result of this enzyme stimulation may be a more rapid metabolism and excretion of other drugs that are simultaneously administered.

The altering of liver enzyme activity is not only a factor in combination therapy but may also be responsible for the development of tolerance to certain drugs. It has been suggested that tolerance may develop to meprobamate (12) as a result of the ability of this agent to stimulate liver enzymes and thus, actually stimulate its own metabolism. Therefore, during long-term therapy with this drug the dose would have to be continually increased to compensate for the loss in pharmacological activity.

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3. *Inhibition of Enzyme Systems*

There are also drugs that can inhibit the activity of liver enzymes. Such compounds as iproniazid (Marsilid—withdrawn from the market) and SKF 525A (an agent used in many experimental studies) can potentiate the activity of many drugs by inhibiting the activity of liver enzymes and delaying the metabolism of the drugs.

The monoamine oxidase inhibitors (Marplan, Niamid, Nardil, Parnate, and Eutonyl) have been shown to inhibit various enzyme systems that may be responsible for metabolizing certain drugs. Many interactions involving the concurrent administration of monoamine oxidase inhibitors with other drugs and dietary items have been reported, and it is probable that enzyme inhibition plays a role in many of these.

The use of disulfiram (Antabuse) in the treatment of alcoholism also involves enzyme inhibition. Evidence indicates that disulfiram inhibits the activity of aldehyde dehydrogenase, thus inhibiting the oxidation of acetaldehyde (an oxidation product of ethanol) resulting in the accumulation of excessive quantities of this agent.

4. *Displacement of Drugs from Proteins*

An interaction of this type may occur when two drugs that are capable of binding to proteins are administered concurrently. Since there are only a limited number of protein binding sites a competition will exist and the drug that has the greater affinity for the binding sites will displace the other from the plasma or tissue proteins. Both phenylbutazone (Butazolidin) and warfarin (Coumadin) are bound to plasma proteins. However, apparently phenylbutazone has a greater affinity for the binding sites, resulting in a displacement of the warfarin, making increased quantities of the free drug available, both to specific sites of biological action and drug metabolizing enzymes (13). In these cases the activity of the anticoagulant would be increased, possibly resulting in a hemorrhaging state. To avoid this problem the dose of the anticoagulant would have to be reduced.

5. *Alteration of Urinary Excretion*

(a) Alteration of urinary pH—The alteration of urinary pH, either done intentionally or unknowingly, can influence the activity of certain drugs. For example, acidifying agents are administered with methenamine to enhance its antibacterial activity. The administration of sodium bicarbonate with several of the older sulfonamides has been recommended to provide an alkaline urine in which the drugs are more soluble, thus reducing the incidence of crystalluria.

One manner by which the urinary pH can influence the activity of a drug is by altering the rate of excretion. When a drug is in its nonionized form it will more readily diffuse from the urine back into the blood. Thus, for an acidic drug like aspirin, there will be a larger proportion of the drug in the nonionized form in an acid urine than in an alkaline urine where it will exist as an ionized salt. The result is that more aspirin will diffuse back into the blood from an acid urine resulting in a prolonged activity.

The opposite will be true for a basic drug like amphetamine or mecamylamine (Inversine). An alkaline urinary pH will favor reabsorption whereas an acid pH will provide a faster excretion of these agents. It has been noted that the effects of a single dose of amphetamine can last for several days if the urinary pH is sufficiently alkaline.

(b) Interference with tubular excretion—It has been known for many years that probenecid (Benemid) can increase the serum levels and prolong the activity of penicillin derivatives by blocking their tubular excretion. A recent report indicates, however, that other factors may also be involved (14). These investigators observed a significant decrease in the apparent volume of distribution of certain penicillin derivatives in the presence of probenecid. This decrease in distribution volume would result in higher serum levels.

6. *Alteration of Electrolyte Levels*

One of the problems associated with the use of many of the newer diuretics

is that they can produce an excessive loss of potassium. This may present a problem in patients being treated with digitalis, many of whom would be candidates for diuretic therapy. If a potassium loss remains uncorrected, the heart may become more sensitive to the effects of digitalis.

7. *Alteration of Receptor Site Interaction*

This mechanism has been suggested to explain the potentiated activity of warfarin in patients receiving dextrothyroxine (Choloxin). Studies have shown that dextrothyroxine apparently does not affect the absorption, distribution, or rate of metabolism of warfarin; neither does it apparently displace it from protein binding sites or reduce the plasma concentration of Vitamin K dependent clotting factors (15). Therefore, it has been suggested that dextrothyroxine can potentiate the effect of warfarin by increasing the affinity of the drug for the receptor site.

8. *Potentiation*

It has been shown that alcohol will potentiate the central nervous system depressant effect of the barbiturates and certain tranquilizers in patients taking these medications. Many other examples of potentiation are also known.

Drug interactions are evident not only among drugs having different therapeutic actions but also among drugs that can be used for the same condition

The following discussion reviews some of the interactions that have been observed with several classes of drugs whose members have frequently been implicated in problems of this type. These particular drugs are considered to give an indication of the frequency with which such interactions can occur unless drug therapy is carefully monitored. In considering these interactions it should be recognized that just because two drugs interact does not mean that they cannot be administered together. Although there are instances where one drug is specifically contraindicated when another is being given, there are many situations where two drugs that are known to interact can be given concomitantly as long as adequate precautions are taken (such as a change in the dose of one or both of the drugs to compensate for the altered therapeutic response).

Analgesics

Drug interactions are evident not only among drugs having different therapeutic actions but also among drugs that can be used for the same condition. There are several examples of this latter type interaction where instead of obtaining an enhanced therapeutic effect by using two drugs, a response is obtained that is less than that obtained from either drug given alone. The classical example of such an antagonism is seen when probenecid (Benemid) and aspirin are administered together. Either drug given alone will produce a significant reduction in serum urate levels but when given together there is an inhibition of uricosuric activity, regardless of which one is given first or how long the patient is pretreated with the first drug before the second one is introduced.

Probenecid may also interfere with the renal excretion of indomethacin (Indocin), another agent that may be used in the treatment of gout (16). However, in these situations the uricosuric action of probenecid is not antagonized as is seen when aspirin and probenecid are administered together.

Another agent that is used in the treatment of gout that might be classified as an analgesic is allopurinol (Zyloprim). It is known that allopurinol will inhibit the oxidation of mercaptopurine (Purinethol) when these agents are administered concomitantly, requiring a reduction in dose of mercaptopurine to approximately one-third to one-fourth of the usual dose.

One of the effects noted with salicylate therapy is that these agents may cause a lowering of blood prothrombin. Because of this, these drugs must be used very carefully, if at all, in patients on anticoagulant therapy. A recent study (17) has indicated that acetaminophen (Tylenol) can also apparently potentiate the effects of anticoagulants.*

Interactions have also been associated with the use of propoxyphene (Darvon) when it has been administered concurrently with orphenadrine (Disipal, Norflex, component of Norgesic). Since mental confusion, anxiety, and tremors have been reported in patients on therapy with both these drugs, their concomitant use is not recommended.

Barbiturates

There have been many reports of an altered therapeutic response to a parti-

* In this study acetaminophen (650 mg. q.i.d.) was administered for two to four weeks in combination with an anticoagulant. A subsequent study (Antlitz, A. M. and Awalt, L. F., Curr. Therap. Res., 11, 360, 1969) indicates that the administration of two 650 mg. doses of acetaminophen (four hours apart) has no effect on the anticoagulant response.

cular drug when it is administered in combination with one of the barbiturates. Although most of the studies have involved the use of phenobarbital it should be anticipated that other barbiturates may cause similar problems.

The role of phenobarbital in stimulating liver enzyme systems that metabolize the coumarin anticoagulants has been discussed and reports indicate that barbital, heptabarbital (Medomin), and butabarbital (Butisol) act in a similar manner (18).

Phenobarbital and diphenylhydantoin (Dilantin) are often prescribed together for the control of epilepsy but occasionally there is difficulty in establishing suitable dosages for these agents. It has been shown that phenobarbital can decrease the plasma levels of diphenylhydantoin (19); however, usually this does not present a significant problem since phenobarbital also has anticonvulsant activity.

Phenobarbital has also been reported to reduce the blood levels of griseofulvin (20). Thus, the dose of griseofulvin might have to be altered in these situations to obtain the desired antifungal activity.

Anticoagulants

The interactions of anticoagulants with other drugs have been reported by many investigators. The consequences of such interactions can be quite serious since it is possible that severe hemorrhaging may result. Most of these interactions have involved the coumarin anticoagulants, primarily bishydroxycoumarin and warfarin, although several problems have also developed following use of the indandione derivatives (phenindione—Hedulin, diphenadione—Dipaxin, and anisindione—Miradon).

The decreased response to the coumarin anticoagulants in patients on phenobarbital therapy has been discussed and it has been observed that chloral hydrate (21) (Noctec) and glutethimide (22) (Doriden) show a similar effect. Other agents such as meprobamate and griseofulvin also cause a decreased activity of the coumarin anticoagulants, requiring an increased dose of the latter while both drugs are administered simultaneously.

These drugs apparently decrease the activity of anticoagulants by increasing the rate at which they are metabolized. However, the opposite may also be true. It has been noted that phenyramidol (Analexin) may inhibit the metabolism of anticoagulants and thereby increase their effect (23).

Other drugs can also potentiate the effect of anticoagulants. It has been mentioned that phenylbutazone can displace warfarin from protein binding sites making increased quantities of free warfarin available. The same effect should be expected with oxyphenbutazone (Tandearil). It is thought that diphenylhydantoin and clofibrate (Atromid-S) also potentiate the activity of concurrently administered anticoagulants by interfering with protein binding (24). With clofibrate the manufacturer suggests that it may be necessary to reduce the dose of the anticoagulant by ⅓ to ½.

Problems may also develop when certain antibiotics such as chloramphenicol and the tetracyclines are administered to patients on anticoagulant therapy (24). Apparently these antibiotics can increase the anticoagulant effect by interfering with the production of Vitamin K, which would antagonize the activity of the anticoagulants, by certain bacteria in the gastrointestinal tract.

A potentiated anticoagulant effect has been observed when certain anabolic steroids are taken concomitantly. Although the mechanism has not been clarified, it has been noted that norethandrolone (15) (Nilevar) and methandrostenolone (25) (Dianabol) can increase the response to certain coumarin anticoagulants. Quinine and quinidine may also show similar effects.

Dextrothyroxine and the salicylates can also increase the response to anticoagulants as has been previously mentioned.

The use of certain enzyme products with anticoagulants is not recommended. For example, the use of Papase is contraindicated in patients on anticoagulant therapy and it is advised that Ananase be given cautiously when prothrombin-depressing drugs are administered concurrently.

The use of anticoagulants warrants very careful supervision even when they are given alone. Certainly when they are administered with other drugs particular attention should be given to the possibility of an interaction. It would be wise to avoid the concomitant use of an anticoagulant with another drug with which it is known to interact, but frequently such combinations can be administered if adequate precautions are taken.

Antidepressants

The potential danger of concurrent administration of monoamine oxidase inhibitors (isocarboxazid—Marplan, nialamide—Niamid, phenelzine—Nardil, tranylcypromine—Parnate, and pargyline—Eutonyl) and sympathomimetic amines is well documented. Although many of these amines, such as amphetamine, are available only by prescription, others such as ephedrine, phenylephrine, and phenylpropanolamine are found in many popular over-the-counter cold remedies. Certainly it would be wise for patients being treated with MAO inhibitors to avoid using products containing these sympathomimetic agents.

There have also been reports of serious reactions (hypertensive crises) occurring in people being treated with monoamine oxidase inhibitors following the ingestion of certain foods having a high tyramine content. These foods include certain cheeses and alcoholic beverages, pickled herring, chicken livers, etc. Tyramine is metabolized by the monoamine oxidases and normally these enzymes in the intestinal wall and in the liver protect against the pressor action of amines in foods. However, when these enzymes are inhibited large quantities of unmetabolized tyramine can accumulate.

MAO inhibitors also should not be administered concurrently with the tricyclic antidepressants (amitriptyline—Elavil, nortriptyline—Aventyl, protriptyline—Vivactil, imipramine—Tofranil, and desipramine—Pertofrane). It is recommended that therapy with one of these agents should not be initiated until at least two weeks after therapy with the other has been discontinued.

It is of interest to note that furazolidone (Furoxone), a chemotherapeutic agent, can also inhibit the monoamine oxidases and it has been suggested that the warnings applying to the use of the other MAO inhibitors should be heeded for this drug also (26).

Other interactions have been reported with the tricyclic antidepressants. One report has indicated that the antihypertensive effect of guanethidine (Ismelin) can be significantly reversed by desipramine and protriptyline (27). Other studies have suggested that sympathomimetic drugs, such as amphetamine and ephedrine, as well as methylphenidate (Ritalin) can also reverse the antihypertensive effect of guanethidine (28).

Antidiabetic Agents

The importance of carefully adjusting the dosage of insulin and oral

antidiabetic agents is certainly recognized. However, it must also be realized that the administration of other drugs with these agents might alter the hypoglycemic response and precipitate a toxic reaction.

It has been reported that sulfaphenazole (Sulfabid) can cause hypoglycemic reactions in tolbutamide-treated patients (29). Since both tolbutamide and sulfaphenazole are bound to serum albumin, it was thought that the additional hypoglycemic activity might be due to a displacement of the tolbutamide from serum-albumin by sulfaphenazole. However, further work points out that this is probably not the primary mechanism by which this reaction occurs since other sulfa drugs, which are also strongly protein bound, do not show the same response.

Other drugs that have been shown to enhance the action of tolbutamide include phenylbutazone, oxyphenbutazone, salicylates, bishydroxycoumarin, and the monoamine oxidase inhibitors (30). It has been suggested that probenecid may also enhance the activity of tolbutamide but a recent study has indicated that this drug does not influence the metabolism of tolbutamide in man (31).

The potentiation of acetohexamide (Dymelor) hypoglycemia by phenylbutazone has recently been described (32) and it has been suggested that phenylbutazone produces this response by interfering with the renal excretion of hydroxyhexamide, the active metabolite of acetohexamide.

The production of a hypoglycemic reaction following the administration of propranolol (Inderal) to insulin-treated diabetics has been observed (33) and it has been warned that this drug may potentiate the action of insulin and oral hypoglycemic agents. An additional danger in these interactions is that the usual hypoglycemic signs associated with catecholamine liberation, such as sweating and tachycardia, may be abolished.

It has been noted that dextrothyroxine (Choloxin) may increase blood sugar levels in diabetic patients (34). Because of this it may be necessary to change the dose of insulin or an oral hypoglycemic agent being administered to these patients.

There are many other interactions that could be discussed but the ones mentioned give an indication of the potential dangers of using certain combinations. This should impress on those individuals who prescribe, dispense, or administer drugs, the importance of exercising extreme caution in the utilization of any drug.

Drug Interactions

Most of the interactions cited in this paper have been outlined in the table below. It should be recognized that the list below is not a complete one but is intended as a quick reference to the interactions that have been discussed in this presentation.

Analgesics	
Aspirin	Benemid Anticoagulants
Zyloprim	Purinethol
Darvon	Disipal, Norflex, Norgesic
Barbiturates	
Phenobarbital	Coumarin anticoagulants Dilantin Griseofulvin
Coumarin anticoagulants	
(Dicumarol, Warfarin, Tromexan, Sintrom, Liquamar)	Phenobarbital Chloral hydrate Doriden Meprobamate Griseofulvin Analexin Butazolidin Tandearil Atromid-S Chloramphenicol Tetracycline Nilevar Dianabol Choloxin Salicylates Papase Ananase
Antidiabetic Agents	
Orinase	Sulfabid Butazolidin Tandearil Dicumarol Salicylates MAO inhibitors Inderal
Antidepressants	
MAO inhibitors (Marplan, Niamid, Nardil, Parnate, Eutonyl)	Sympathomimetic drugs (amphetamine, etc.) Foods with high tyramine content Tricyclic antidepressants (Elavil, Aventyl, Vivactil, Tofranil, Pertofrane)
Tricyclic antidepressants	MAO inhibitors guanethidine

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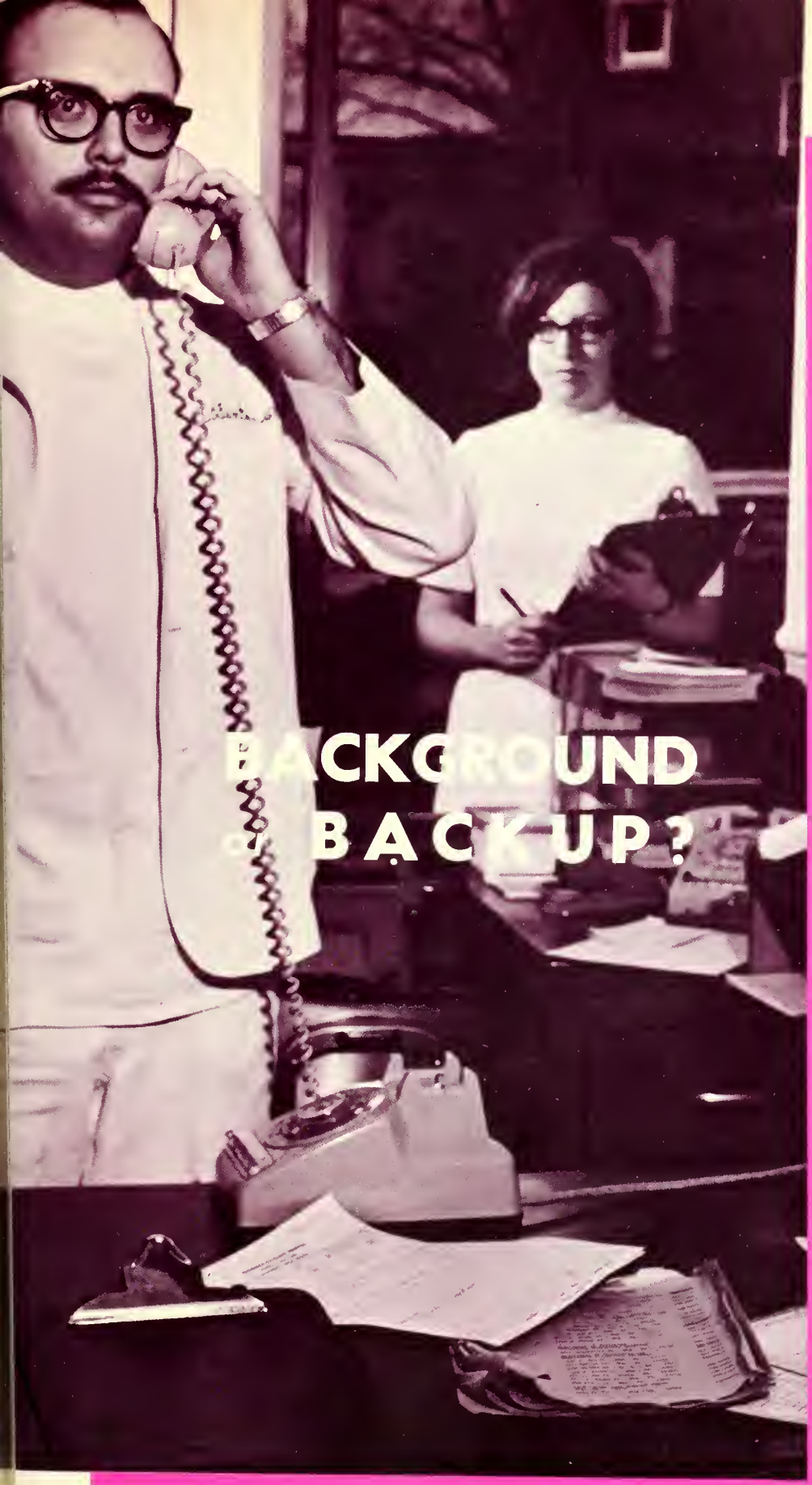

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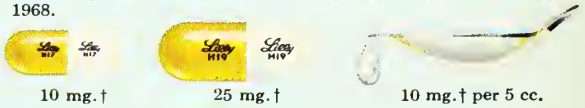
*Mendels, J.: Comparative Trial of Nortriptyline and Amitriptyline in 100 Depressed Patients, Amer. J. Psychiat., *124*:59 (Feb. Supp.), 1968.



10 mg.† 25 mg.† 10 mg.† per 5 cc.

†base equivalent

AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

Lilly

See next page for prescribing information.

900816

AVENTYL® HCl
NORTRIPTYLINE HYDROCHLORIDE

Description: Aventyl HCl is a safe and effective agent for treatment of mental depression, anxiety-tension states, and psychophysiological gastro-intestinal disorders. It is not a monoamineoxidase (MAO) inhibitor.

In laboratory animals, anticholinergic effects of Aventyl HCl are milder than those of related antidepressants.

Indications: Depressive reactions (alone or accompanied by anxiety) associated with such presenting symptoms as depression, anxiety, tension, insomnia, restlessness, disinterest, and irritability.

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Contraindications: Hypersensitivity to the drug; concurrent use with a MAO inhibitor or use within two weeks after the MAO inhibitor is discontinued.

Warnings: Use in convulsive or hypotensive states should be closely followed by the physician.

At present, data are insufficient to recommend the drug during pregnancy. The possibility of a suicidal attempt in a depressed patient should always be considered.

There have been rare reports of agranulocytosis, jaundice, hypotension, tremor, urinary retention, thrombocytopenic purpura, and paralytic ileus. Periodic laboratory studies are recommended.

Cardiovascular complications, including myocardial infarction and arrhythmias, have been reported occasionally with related drugs. Patients with cardiovascular disease should be given Aventyl HCl under close observation and in low dosage. This drug, like members of its group, tends to produce sinus tachycardia and to prolong the conduction time, as manifested by first-degree AV block.

Precautions: Because of its anticholinergic activity, Aventyl HCl should be administered cautiously in patients with glaucoma or a propensity for urinary retention. Use Aventyl HCl with care in conjunction with sympathomimetic or anticholinergic drugs. Epileptiform seizures or troublesome patient hostility may occur. Aventyl HCl used alone in schizophrenic patients may result in an exacerbation of the psychosis.

Concomitant use of Aventyl HCl and ECT (with or without atropine, short-acting barbiturate, and muscle relaxant) has not been thoroughly studied. If these treatments are used together, the physician should be aware of possible added adverse effects.

Patients should be warned about the possibility of drowsiness if they operate dangerous machinery or drive a vehicle. Concurrent ingestion of other C.N.S. drugs or alcohol may potentiate the adverse effects of Aventyl HCl.

Patients receiving a tricyclic antidepressant (e.g., nortriptyline) may respond poorly to hypotensive agents such as guanethidine.

Adverse Reactions: The following have been observed or reported following the use of Aventyl HCl: dryness of mouth, drowsiness, constipation, dizziness, tremulousness, confusional state, ataxia, disorientation and hallucinations, restlessness, weakness, precipitation of hypomanic or manic state, tachycardia, blurred vision, epigastric distress, sweating, peculiar taste, black tongue, fatigue, excess weight gain or weight loss, insomnia, headache, paresthesia, nausea and vomiting, adynamic ileus, rash, itching, delayed micturition, hunger sensation, flushing, diarrhea, nocturia, inner nervousness, anxiety and panic, ankle and orbital edema, hypotension, hypertension, impotence, nightmares, palpitation, numbness, peripheral neuropathy, photosensitization, extrapyramidal symptoms, and increased or decreased libido.

Habituation or withdrawal symptoms have not been reported.

Administration and Dosage: Aventyl HCl is administered orally as Pulvules® or liquid. Dosage should be individualized. The following general principles are applicable.

Aventyl HCl is preferably given in gradually increasing doses: 1 Pulvule (10 mg.) twice the first day, 1 Pulvule three times the second day, and 1 Pulvule four times daily thereafter.

If neither beneficial nor adverse effects are seen after five to seven days with 10 mg. four times a day, the patient can be given 25 mg. twice the first day, 25 mg. three times the second day, and 25 mg. four times daily thereafter.

If minor side-effects develop, reduce the dosage. If side-effects of a more serious nature or allergic manifestations develop, discontinue the drug.

For mild symptoms of a depressive nature, give 10 mg. three or four times a day; for severe depressions, 100 mg. daily.

Dosages above 100 mg. daily seem to induce no greater degree of clinical response, but side-effects may increase.

Usual Recommended Dosage

ADULTS—20 to 100 mg. daily

Pulvules: 25 mg.—1 Pulvule one to four times daily
10 mg.—1 or 2 Pulvules one to four times daily

Liquid: 1 to 2 teaspoonfuls (5 to 10 cc.) one to four times daily

CHILDREN—1 to 2 mg. per Kg. or 10 to 75 mg. daily

Pulvules: 25 mg.—Ages seven to twelve, 1 Pulvule one to three times daily
10 mg.—Ages three to six, 1 Pulvule one to three times daily
Ages seven to twelve, 1 or 2 Pulvules one to three times daily

Liquid: Ages three to six, 1 teaspoonful (5 cc.) one to three times daily
Ages seven to twelve, 1 to 2 teaspoonfuls (5 to 10 cc.) one to three times daily

Maintenance medication is necessary until it is evident that the depression cycle has run its spontaneous course. This assumption may be based upon the history of previous depressions, the removal of the precipitating factors in the environment, or a recognition that the patient is able to manage his affairs. It is advisable to continue maintenance therapy for several months after improvement.

How Supplied: Liquid Aventyl® HCl (nortriptyline hydrochloride, Lilly), 10 mg. (equivalent to base) per 5 cc., in pint bottles.

Pulvules Aventyl HCl, 10 and 25 mg. (equivalent to base), in bottles of 100 and 500. [OB1668A]

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The Need for the Physician's Support of the Nurse in Day-to-Day Practice

LUCY D. GERMAIN
Philadelphia

This article is written with a background of fine relationships with doctors in the author's day-to-day practice, of observations of doctors and nurses working together in hospitals and elsewhere in the United States and abroad and in discussion groups in many hospitals and other health facilities and agencies.

Upon first reading this title is startling. It is unexpected. Through the years many a doctor has expressed the need for the nurse to help him and expected it. His very word was law irrespective of the subject or situation at hand. The nurse was to do and not think.

Today this is no longer acceptable to the patient or to the nurse. The patient knows that over a longer period of time the nurse is closer to him than the doctor. The nurse knows the doctor can make the working environment pleasant or otherwise by his reactions, his overprescription and unwillingness to really accept suggestions in nursing notes and nursing observations. In turn many doctors have yet to fully recognize how they are a contributing cause of undue stress, dissatisfaction and resignations. Very pleasant working relationships exist most of the time although these exceptions exist.

The day-to-day practice of the physician and nurse requires mutual support if each is to be effective. "Mr." patient is the focus of their performance both separately and together. He is recipient of the care each provides.

The physician and the nurse are the chief members of the health team. It is important, however, to recognize the participation of members of other health disciplines. "Mr." patient is also a member. Much depends upon him, his cooperation and understanding, the degree of his wellness or illness, and his mental, physical and emotional responses. The doctor and nurse tailor their knowledge and skills to the contributions "Mr." patient makes to his own care, so their efforts will be more effective. The physician and the nurse are accountable to "Mr." patient and hence to society for the quality, availability and quantity of the respective professional service whenever and wherever it is needed.

The doctor-nurse relationship is similar, whatever the environmental setting—home, school, hospital, office, industry, clinic, or extended care facility. The more acute or serious the needs of "Mr." Patient, the closer the members of each profession must work together. In some instances "Mr." patient is in a client relationship as the degree of his participation will vary according to his need for dependency. As the doctor and nurse plan for the patient according to the doctor's plan for medical care, their degree of dependency on each other will also vary, e.g., a patient going to an extended care facility requires more direct nursing care than direct medical care while in the doctor's office the care is more medical per se. Wherever the doctor and nurse work together each respects the contribution of the other, yet recognizes the skills, knowledge, social concepts and attitudes inherent in himself and his profession. The attributes of one should enhance the work of the other.

Although this subject deals with only one side of the coin—the physician's support of the nurse, one should remember the support the nurse gives the physician is equally important. When life was less demanding, living more simple, medical and nursing care given with greater ease, in smaller and less complex health facilities, the support of the doctor and nurse for each other was evident and came readily. Each gave of himself directly for the patient. The doctor-patient-nurse relationship was on a one-to-one basis.

Today the situation has changed. The increase in population has required more doctors, nurses and other health personnel involved in providing care for people. Huge medical

centers in which are concentrated technical, equipment, medical research and highly skilled personnel can depersonalize the care of the patient. Tensions are higher and speed and workload demand much of the doctor and nurse. The vast increase in medical knowledge, drugs, more intricate and complex treatments and the use of more machines and equipment have taken the doctor and nurse farther apart. The consumer public is knowledgeable, desires, and should have the expert delivery of medical care and nursing care, with the warmth received by his parents and grandparents. Third party payers are now in the picture, too. Support rather than help becomes a need of both the doctor and the nurse if their services to people are to be acceptable in this changing world.

Who is this patient? He is a human being in need of health care and in an acute short stay hospital he can be lost in the maze of tubes, monitors, suctions, and other machines. He is in an environment totally foreign to him and all too frequently separated too long a time from family and loved ones. The technical aspects of medicine and nursing predominate in order to meet his health needs. At this point in time the warm, mutual understanding of the doctor and nurse for him is evident only as each stay close by, express their concern through voice and action and exemplify the art of their respective professions.

Support means different things to different people. To the author it means (1) harnessing the skills and knowledge of the doctor and nurse to provide medical and nursing care, (2) expecting each practitioner to understand and collaborate with the other, (3) anticipating that each will help to create a climate conducive to good care and high performance, and (4) being an ally in the true sense of the word to the end that the health needs of "Mr." patient will be met. The physician expects the nurse to function to the limit of her ability and knowledge. Likewise, the nurse expects the same quality of performance from the doctor.

Also, the physician should know and evaluate the impact of his demands on the nurse as he prescribes for the patient—how the nurse reacts to the stress and strain of a highly charged environment of medical practice today. All too often the nurse only has the diagnosis available or the decision that "Mr." patient is going to surgery. Actual planning is absent or taken for granted and written orders are the only communication, incomplete, scanty and illegible as they may be.

There are positive ways for the physician to support the nurse in day-to-day practice. None are really new. They exist to greater or less degree where members of the two health disciplines work as partners. This is especially so where the association has been a long one. It is also true in the newer services, such as community mental health centers or in-patient psychiatric units in general hospitals and other new endeavors where physicians and nurses plan the facilities and jointly determine the care and

how it will be given and the overall policies and practices to be followed as, for example, in intensive care units, cardiac care units or in revitalizing the quality of care given throughout the facility.

Of course such a partnership develops more readily when patients stay longer in hospitals, professional nurse staffing is stable and doctors take their responsibility to the institution seriously. The challenge is to find ways to maintain the partnership approach even if the patient stay is shorter, the pace is faster, the prescribed medical care more intense and the need for more adequate nursing care is ever present.

The following are suggestions for meeting the challenge:

1. More adequate orientation of the physician upon his appointment, whether it be to the medical staff, as chief of staff or chairman of a committee. All too frequently this is limited to a conference with the administrator, the chief/president of the medical staff or the head of the particular clinical service. Little attempt is made to acquaint him with the policies or practices governing day-to-day patient care, such as the admission of patients, information about other employed professionals, the interpretation of the rules and regulations of the medical staff and hospitals as they relate to prescribing drugs, diets, or orders for procedures whether surgical, diagnostic or therapeutic.
   The orientation might be structured to contain:
   a. Organization, philosophy and function of the health facility.
   b. Programs and policies of services the physician will use repeatedly, such as admitting, nursing, radiology, laboratory, social service, dietary, pharmacy, central service, etc.
   c. General interpretation of the function of each service and who is responsible for it, e.g., the director of nursing service selects nursing personnel and provides for standards of nursing practice wherever a nurse or other members of the nursing staff give nursing care to patients or participate in research.
   d. Procedures as they relate to the well-being of the patients, e.g., all previous orders are cancelled when a patient goes to the operating room; all orders must be written; the home care program.
   e. The educational programs.
   f. What the hospital or clinic expects from the physician.
   g. Explaining the nursing service (and other services directly related to the physician and his work).
   This information is usually omitted unless it is intiated by the physician himself or by the director of nursing service. This is an impressive and effective method to show how the physician can support the nurse and assure better care for the patient. It affords an opportunity for each to become acquainted with the other, for the physician to learn about nursing service and the basic qualifications of each category of personnel participating in the care of patients, the expression on his part of his expectations of the service, the goals each share in providing care for people, and for the physician to determine early how he can collaborate with the personnel responsible for his patients twenty-four hours a day.
2. Adjusting the care of patients according to newer medical practices, community programs and/or hospital services.
   It is appropriate and timely for physicians and nurses to review the respective care regimes for patients with conditions commonly found in the hospital, clinic or the community, e.g., diabetes, cancer, heart, burns, pre and post-operative care or diagnostic or therapeutic procedures, and to discuss the physical and mental preparation of the patient. It is important to keep abreast of medical and nursing research, to share findings and to initiate new patterns of care based upon their application.
3. Initiating a new clinical service.
   The physician and nurse planning together for a new service opens the way for a continuing colleague relationship. this may be in the care of the alcoholic, the adolescent or the geriatic patient. The environment is physical and personal. If the physician is the only one who has been given a voice in planning the physical facilities, they will not necessarily support the nurse in day-to-day practice. The same is true if the nurse plans apart from the physician.
4. Initiating a research project, a new treatment or recommendations for new equipment.
   This relates to the direct care given to "Mr." patient and should be discussed with the director of nursing service or her designate, before finalizing plans. Any innovation involves pre-planning and good understanding by those involved if the effort is to succeed. If this is not the practice, then no one knows the goals or expectations and undue stress is placed on an unsuspecting and unprepared staff. It may well be that more staff is required, that the plan demands a level of practice beyond present prepara-

tion or the workload already is as heavy as it can be and still maintain staff satisfaction. The doctor just can't decide to change his method of procedure or write an order or start an investigative process and expect it to happen—not if he has genuine concern for his patient and wishes to give the nurse support in her day-to-day practice.

5. Knowledge of the legal responsibilities of the nurse.

   The nurse is responsible for his own acts. In order to safeguard the patient and the nurse, the doctor should know the nurse is adequately prepared, functions within the limits of nursing practice and the policy of the institution. The physician hopefully knows the safeguards established for the nurse to follow and willingly helps to maintain them.

6. The physician and the nurse specialist.

   There is an increasing number of nurse specialists, well prepared in a clinical field of nursing, employed in positions close to patients. They give direct care and teach others. There are those, too, who through experience and self-learning, have outstanding ability to observe and evaluate the condition of patients. They have a deep commitment to the patient. Physicians should know about these nurses and the high quality of care they give. Hopefully, he will find this depth of knowledge of particular value and use both the written and verbalized observations to the utmost.

7. Writing Orders.

   Plans for medical care should be clearly, legibly and concisely written, signed by the doctor, leaving no doubt whatever what is to be done. If a medication, the what, when, and mode of administration should always be indicated, as well as the period of time the order is to be in effect.

8. Nurse participation in physicians' activities.

   The physician should expect and request that nurses actively participate on patient care committees, conferences, pa-

tient rounds and especially on infection, utilization and similar committees for planning and review. The interaction between the physician, nurse and representatives of other health disciplines brings about better understanding and ongoing support for the nurse in day-to-day practice.

If these suggestions are already custom wherever the doctor and nurse work together then the need for the physician to support the nurse is a reality. His teamwork with the nurse would be evident to the patient. Hopefully, he would desist from performing minor surgical procedures on inpatient care areas and do them in the operating room. He would know the method used for isolation technique and follow it.

Patient care rounds, more commonly called doctors' rounds, are frequently rapid, barren of information and center frequently on teaching house staff. All too often a nurse is not present and this important channel of doctor-nurse-patient interaction is lost. The following example is descriptive of an all too frequent happening:

> "Mr. X", a known diabetic, was admitted to the hospital for further study and establishment of a new regime. At home he had difficulty administering his own insulin. The doctor failed to inform the nurse. Hence, it took several days for the nursing staff to fully comprehend and to plan accordingly. "Mr. X" lost time from work unnecessarily, the hospital stay was prolonged and "Mr. X" sensed the need for better coordinated effort between the doctor and nurse.

In order to give support, the doctor needs to know what is expected of the nurse and how he can best contribute. Barbara Bates, M.D., describes how a doctor supports or fails to support the nurse by the kind of orders he writes. She shows how a doctor, unless he understands the full impact of the orders he writes, may complicate the work of his nurse partner, lay the groundwork for unsafe patient care, add unnecessary work for the nurse, contribute to a stressful situation, force misuse of scarce professional nurse hours and undermine the foundation of the nurse practitioner.

Important as the interpersonal relationships between the doctor and the nurse may be, a crucial point in un-

derstanding comes as the nurse participates in the medical regime—carrying out the doctor's prescription for "Mr." patient. Here the understanding of the physician is most important. Is his thinking geared to only a one to one relationship between the patient and nurse, e.g., the special duty nurse? Is he really aware of what the orders mean in time alone? A few examples of some such orders are: (1) tube feed every hour, (2) record intake and output every hour, (3) take pulse and blood pressure every fifteen minutes. The physician can give tangible support to the nurse by close supervision of his own and house staff performance and by altering the orders as quickly as condition permits.

The more the physician knows about how nursing care is determined, policies established, and the staff prepared the better it is. He will be less likely to request the nurse to go beyond the limits of nursing practice. He should know they are determined by the director of nursing service with her staff. The background for the decision may come from nursing service for the safety of both the patient and nurse or be the broad policy of the employer or the rules and regulations governing the medical staff or joint thinking of representative physicians and nurses. Among the examples of such policies are (1) nurses may give medications intramuscularly but those given intravenously either directly or by infusion are the responsibility of a physician (2) nurses may perform more medically-oriented responsibilities only under stated written conditions and always with the approval of the director of nursing service.

The need for the physician's support of the nurse is also evident where there are educational programs in the health professions. Such support contributes much to the environment in which residents and interns learn how to practice, and student nurses learn to give nursing care; where the preceptors or leaders make every effort to develop an appreciation of people, where the learning takes place for the doctor and nurse to-be in a patient-centered environment where other professional health personnel learn or practice.

Learning to work together is better accomplished where appropriate groups learn together in basic educational programs. Courses in the behavioral sciences, community planning, family welfare, methods of research and seminars focused on the care of people are cited as examples.

The focus of this presentation has been on the need for the physician's support of the nurse in day-to-day practice to improve the delivery of health care through cooperative effort. It is a two-way process in order for both the physician and nurse to perform effectively. The lack of cooperation if it does exist, is not necessarily the fault of members of the two disciplines but rather of the times. It can be overcome by the awareness that back of every physician and every nurse is a human being with a commitment to the service of people. In order for this commitment to be effective, there must be a partnership. This is based on mutual understanding and willingness to communicate in the interest of all the "Mr." patients in the world.

Lucy D. Germain is associate administrator of Pennsylvania Hospital, Philadelphia. She holds a bachelor's degree in nursing and received her master's degree in vocational education and science from the University of Michigan. Prior to her service at Pennsylvania Hospital she was executive director of the American Journal of Nursing Co. in New York City.

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You get him off to a good start.
With U.S. Savings Bonds.
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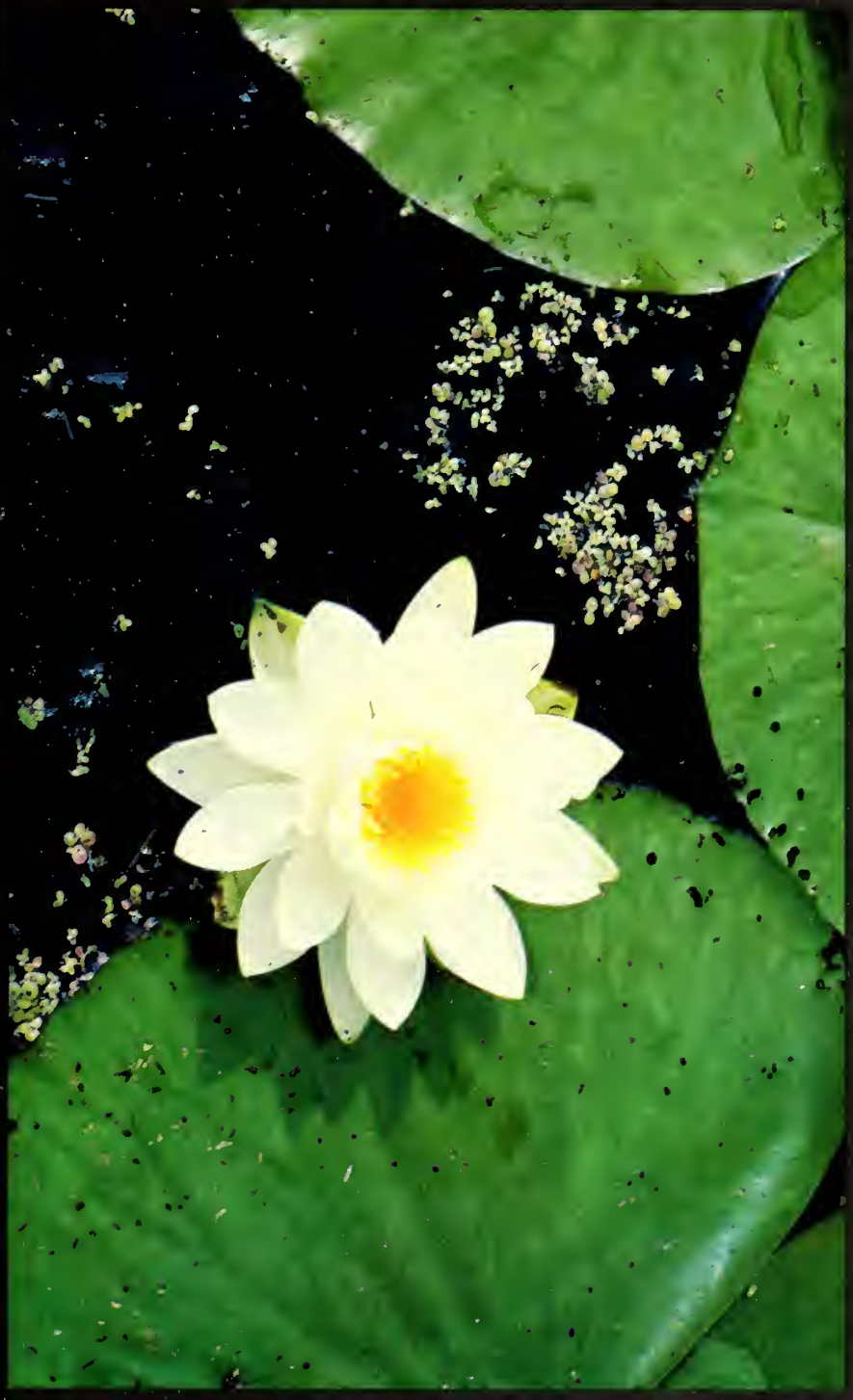


Is there more than one way to gild the lily?

FOR THE DO-IT-YOURSELF DEVASTATOR, MAY WE RECOMMEND INDUSTRIAL WASTE AND SEWAGE DISPOSAL FOR A START. FOR THE DOC THAT LIKES HIS BLOSSOM WITHOUT THE PALLOR OF POLLUTION AND AN OIL SLICK SYNDROME, MAY WE RECOMMEND YOU JOIN THE FIGHT AGAINST THE LIVID LILY.

PENNSYLVANIA MEDICAL SOCIETY — ORGANIZED 1848 — CHARTERED 1849 — AMA 1847

Write to the Pennsylvania Medical Society today for details.

Commentary on Clean Air Controls

Dear Editor:

I would like to comment on the fine article "In Recognition of Clean Air Week" by Charles E. Myers, M.D., in the October issue of PENNSYLVANIA MEDICINE. It is vitally important that we as physicians go on record to let the Governor and his commission know our views regarding adoption of stricter air quality standards for Pennsylvania.

The difficulty of imposing more stringent controls on air pollution has already been indicated by the immediate negative reactions to the recommended standards from two commission members. As physicians, we have the right to demand an explanation from the Governor as to why the Air Pollution Control Commission, which is charged with controlling air pollution, should be headed by a representative of a polluting industry. It is time that the Governor quit putting "the fox in charge of the hen house."

The figures advanced by the commission were vociferously criticized by both expert and lay witnesses in recent public hearings in Pittsburgh and Philadelphia. The lax standards originally proposed would have made Pennsylvania the only state to disregard the air quality guidelines suggested by the National Air Pollution Control Administration and would have legalized an air pollution level at which adverse health effects have been shown to occur.

As physicians, we must take a strong stand. Pennsylvania, under the standards established by the Federal Air Quality Act, has adopted what could be really effective controls on air pollution. Since the requirements have been met on paper—we have only to ask "Will they be adhered to?" There is no doubt that pressure will have to be exerted on the Commonwealth's Air Pollution Control Commission by the people and by the Governor who appoints the commission's members—including the five cabinet members who sit on the control body.

We physicians have the right—and more important the obligation—to demand results.

J. T. McClowry, M.D.
Springdale, Pa.
Member, Allegheny County
Medical Society Committee on
Preventive Medicine and
Public Health

(Editor's Note: Dr. McClowry's hometown of Springdale, more infamously described by him as "the dirtiest community in Pennsylvania" because of serious air pollution problems, is located approximately 15 miles northeast of center city Pittsburgh on the Allegheny River. Within its square-mile boundaries are situated two coal-burning public utility industries, with another recently built immediately outside the border.)

"I.Q." Appeal

Dear Doctor:

Cigarette smoking is directly responsible for the premature death of more than 125,000 Americans each year. In 1960, the American Cancer Society launched a program of public education on the risks of cigarette smoking which was followed by the Surgeon General's 1964 report, then further stressed by the multi-agency concern for the dangers of cigarette smoking.

Today there are 21,000,000 ex-smokers. More than 100,000 physicians have quit. To assist people who still smoke, and those desiring to stop, the American Cancer Society has launched the "I.Q. (I Quit Smoking) Clinics and Clubs" program. I am serving as Pennsylvania's chairman for the program—and I need your help.

The physicians' image, especially that of the non-smokers, is most influential. They have the best opportunity and the most persuasive means of convincing patients of the dangers of smoking to health.

If you are concerned about this critical health problem, would you show your concern by exercising your influence in whatever way you can to encourage smokers to quit? In coming months, you may be asked to wear an I.Q. pin, place a sign in your office, speak at an I.Q. clinic, or even write an article.

I believe constant repetition and reinforcement of the basic concepts will provide the best long-range solution to the smoking problem. The mushrooming effect of non-smoking physicians influencing parents who will inform their children, ultimately will influence young people to stop smoking before they start.

Sincerely,
Catherine B. Hess, M.D.
Director of Chronic Diseases
Pennsylvania Department of Health

PENNSYLVANIA MEDICINE cardiovascular briefs

Management of Peripheral Arterial Diseases

Part I

■ **Meyer Naide, M.D., Director, Division of Vascular Diseases, Graduate Hospital of the University of Pennsylvania, and David Naide, M.D., Division of Vascular Diseases, Graduate Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania, are questioned by William G. Leaman, Jr., M.D.**

What are the predisposing factors in peripheral arterial occlusive diseases?

Generally, the conditions which predispose an individual to atherosclerosis will also lead to an increased incidence of peripheral, as well as coronary and cerebral vascular disease. These include diabetes, hypertension and diseases with abnormally high lipids. Also of importance is any inherited tendency toward the development of atherosclerosis.

How does one evaluate the patient with a femoral artery occlusion?

By palpation of pulses in the feet and checking them with an oscillometer or an ordinary sphygmomanometer, either aneroid or mercury, with the cuff at the ankle and inflating to about mid-way between the systolic and diastolic pressure. The movement of the pointer through one to two millimeters is normal. One listens for a bruit over the abdomen and over the femoral artery. Feeling for a difference in temperature between the two feet is important. The rate of blanching of the foot on elevation is determined; the feet should be pink for at least 30 seconds. The patient then sits with the legs dependent; normally, the toes should flush within five seconds. If one foot remains pale and the other becomes pink, the pale foot is ischemic. The examination of the skin on the foot is important to determine the presence of ulceration. Finally, if arterial surgery is considered, arteriography is done.

How does one manage acute femoral artery occlusion which is not embolic?

Sudden arterial occlusion not due to embolus implies thrombosis of an artery with chronic atherosclerosis. With some degree of previous narrowing, collaterals may have formed so that the degree of peripheral ischemia is not usually as severe as with an embolus. The first step in treatment would be to do a continuous epidural block. If significant improvement is not apparent within several hours the limb is of questionable viability, then arteriography is indicated with a view toward arterial reconstructive surgery. Operation, however, is not as much of an emergency as it is with a peripheral embolus because of usually pre-existing collaterals.

What is the most common cause of claudication in the presence of good pulse (pseudo-claudication syndrome)?

With a proximal (aorto-iliac) stenosis there may not be enough peripheral blood flow to prevent claudication, yet pedal pulses may be present. This can be diagnosed by rechecking pedal pulses and oscillations after exercise. If the above situation is present, after exercise, the pedal pulses often disappear and the oscillations become markedly diminished. This does not occur in the normal individual.

What are other explanations of the pseudo-claudication syndrome?

Occasionally, the calf muscular arteries are occluded by an arteritis or microemboli producing claudication. Rarely one sees symptoms of claudication due to a herniated intervertebral disc or narrowing of lumbar arteries supplying the motor roots of the spinal cord. The former can be shown by a myelogram; the latter is difficult to prove.

What is the clinical picture of micro-embolism?

Microemboli are tiny, sometimes microscopic, fragments of cholesterol and/or clumps of platelets which break loose from an ulcerated or roughened plaque of arteriosclerosis in the abdominal aorta, iliac, femoral or popliteal vessels. These are also commonly seen in patients with eneurysms. Embolic fragments lodge in the small end arterioles producing many, often scattered, small skin infarctions. If a patient presents with multiple scattered, small ischemic areas, such as several ischemic toes plus ischemic areas on the lower extremities, the diagnosis of micro-embolism should be suspected. Aortography is helpful in making the diagnosis. Surgical resection and replacement with an arterial graft is the treatment of choice. A second choice may be long-term anticoagulant therapy.

Should arteriography be done on all patients with arterial occlusive disease?

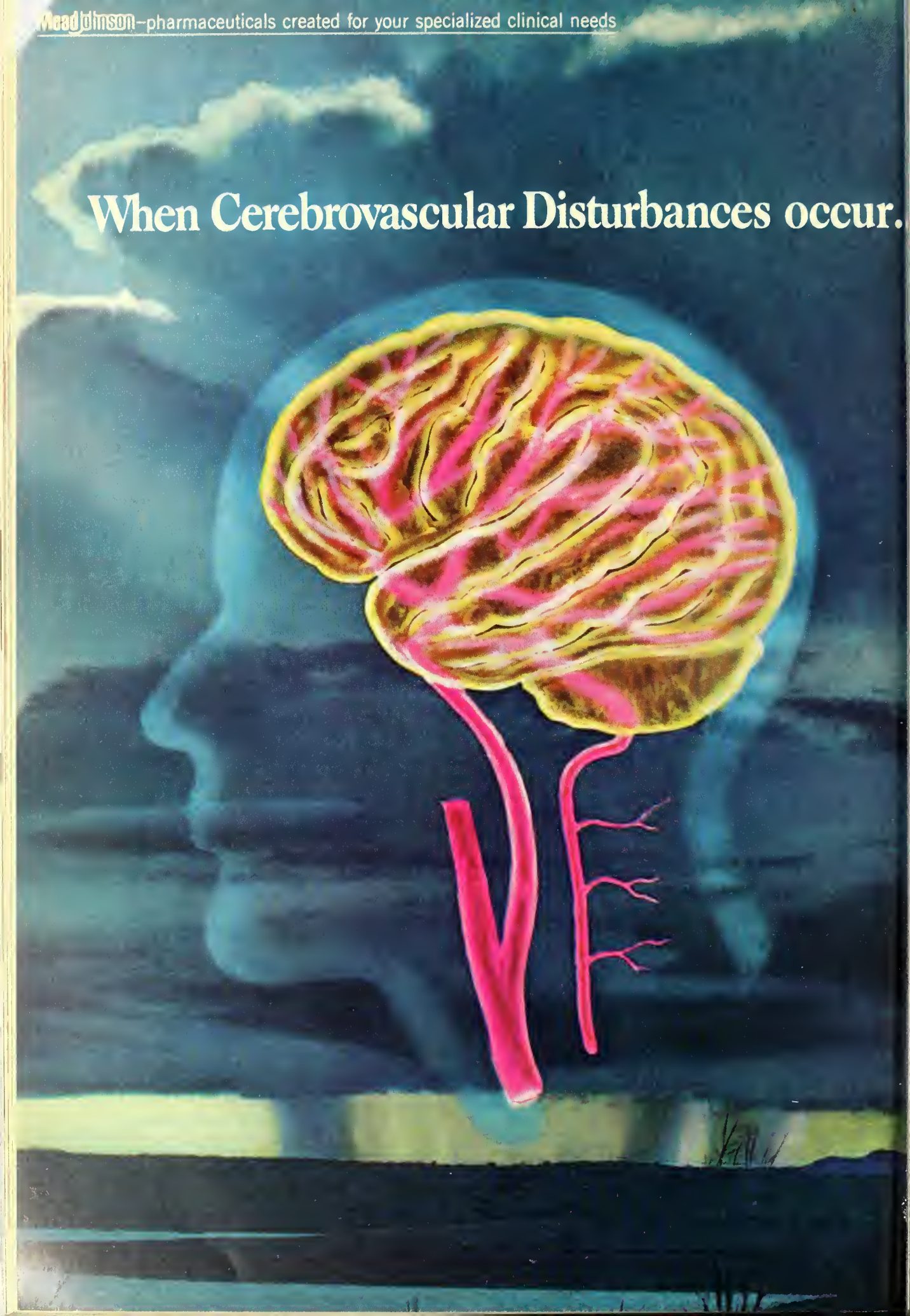
No. Arteriography should not be done unless one is contemplating arterial reconstructive surgery.

What is the place of sympathectomy in arterial occlusive disease?

It still has a place in the treatment of peripheral ischemia. In some patients with severe ischemia, arterial reconstructive surgery is not possible, because of poor or no run-off. Sympathectomy is more likely to increase skin blood flow such as to an ischemic lesion. Claudication, however, is unlikely to benefit.

■ **William G. Leaman, Jr., M.D., edited this brief for the Council on Education and Science, in cooperation with the Pennsylvania Heart Association.**

When Cerebrovascular Disturbances occur.



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Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODĪLAN tablets, isoxsuprine hydrochloride 10 mg. **Dosage:** Oral—10 to 20 mg. (1 or 2 tablets) t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. As intramuscular administration of 10 mg. or more may cause brief hypotension and tachycardia, single intramuscular doses exceeding this amount are not recommended. Complete details available in product brochure from Mead Johnson Laboratories. **References:** (1) Fazekas, J. F.; Alman, R. W.; Ticktin, H. E.; Ehrmantraut, W. R., and Savarese, C. J.: Angiology *15*:No. 2 (Feb.) 1964. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Clarkson, T. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (4) Dhrymiotis, A. D., and Whittier, J. R.: Current Therapeutic Research *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964

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PENNSYLVANIA MEDICINE

cancer forum

The Physician's Role in Smoking and Health

The Background

Since the first observation of an association between lung cancer and the smoking of cigarettes, evidence has steadily accumulated that cigarettes are a serious threat to health. Epidemiological, experimental, pathological and clinical studies have all demonstrated that cigarette smoking is hazardous.

The American Cancer Society began in 1949 its support of research into the relationship of cigarette smoking to cancer. The society launched the first of its public health education programs on the risks of cigarette smoking in 1960. In that year the society declared "beyond reasonable doubt cigarette smoking is the major cause of the unprecedented increase in lung cancer." Lung cancer mortality was then 36,-520; in 1968 is it expected to be 55,000, and the toll is still rising.

Although early findings were mainly about lung and oral cancer, later research revealed an association between cigarettes and cancer of the larynx, esophagus, and bladder. In addition, it was found that cigarette smoking contributed to cardiovascular disease, chronic bronchitis and emphysema. The extent of this broad relationship of cigarette smoking to illness, disability and death was emphasized in the Report of the Advisory Committee to the Surgeon General of the Public Health Service in 1964 and in the PHS Review "The Health Consequences of Smoking" in 1967.

Since 1960, there have been many changes in cigarette smoking. Smokers have shifted in ever-increasing numbers to filters. The Federal Communications Commission and the Federal Trade Commission have taken vigorous action. The Congress has required a warning on all cigarette packages. The Public Health Service's Clearinghouse for Smoking and Health sponsors impressive behavioral research and public education. Twenty-two health, educational, and governmental organizations have united in the National Interagency Council on Smoking and Health to exchange information, consider over-all plans, and to stimulate independent and joint action.

While medical research has produced a clear picture of the threat of cigarettes, their social acceptability and the energy with which they are promoted have not been reduced. The American Cancer Society believes in freedom of choice and the right of adults to decide whether to smoke cigarettes, but we do not see enough real freedom on this decision in our cigarette infiltrated world. Adult example, peer invitation, glamorous advertising make it too easy for youngsters to start cigarette smoking; and the adult smoker finds his habit confirmed not only by each cigarette he smokes but by a variety of social pressures. Farmers, merchandisers, manufacturers, advertising agencies, newspapers and magazines, publishers and broadcasters draw large income from cigarettes. Tax benefits are considerable to federal, state and city governments.

Important is the fact that men and women of talent, backed by three hundred million dollars annually from the tobacco industry, devote themselves to advertising cigarettes, to arguing with research data and countering warnings of the health risk. Influential, also, is the seductive appeal of cigarette smoking in films and on television by actors, commentators and public figures.

In the face of social acceptance, economic dependence, and vigorous propaganda on behalf of cigarette smoking, it is encouraging that there are today about twenty-one million ex-cigarette smokers, that more than half of adult Americans do not smoke cigarettes, that about one in five men who once smoked cigarettes has given up the habit, that some 100,000 physicians—half of those who smoked—have quit cigarettes. Fortunately, the wish to maintain health is very strong. When a threat to life is felt as personal and real, men and women are able to do remarkable things to protect themselves—including giving up cigarette smoking.

What Can Be Done?

Possibilities of cure of lung cancer remain limited. Prevention of the diseases is the major hope and, to achieve this, public attitudes and individual behavior must be drastically altered.

Physicians—especially those who have quit cigarette smoking—are the most important health educators and have the best opportunity to convince cigarette smokers that they are damaging their lung function now and inviting serious illness later. The physician can be especially helpful by involving himself in programs to persuade smokers not to smoke.

Many agencies, such as the American Cancer Society, are developing community anti-cigarette programs built around face-to-face efforts to influence individual behavior. Physicians should become involved in these activities to demonstrate the seriousness of the problem and to assist in efforts to help smokers stop the habit.

Ultimately, it is apparent that one of the most effective methods to reduce smoking is by example. Members of the health professions—especially physicians—should recognize that their personal example is important in influencing the smoking habits of both adults and youngsters.

CANCER FORUM – presented cooperatively by the PMS Council on Education and Science, The Pennsylvania and Philadelphia Divisions of the American Cancer Society, and the Cancer Control Section, Pennsylvania Department of Health.

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It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

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You might also say that all interns aren't alike, either.

Mild ulcerative colitis may be triggered here...

In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

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CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-

or here.

ad). Though generally not recommended, if combination therapy with other psychotropics sms indicated, carefully consider individual armacologic effects, particularly in use of potiating drugs such as MAO inhibitors and enothiazines. Observe usual precautions in sence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulaon and acute rage) have been reported in psyatric patients. Employ usual precautions in atment of anxiety states with evidence of imding depression; suicidal tendencies may be sent and protective measures necessary. Varie effects on blood coagulation have been orted very rarely in patients receiving the g and oral anticoagulants; causal relationslo has not been established clinically.

DVERSE REACTIONS: No side effects or nifestations not seen with either compound ne have been reported with Librax. When lordiazepoxide hydrochloride is used alone, wsiness, ataxia and confusion may occur, ecially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

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With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

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Proceedings of the House of Delegates

One Hundred and Twentieth Annual Session Philadelphia, Pennsylvania — October 9-11, 1969

The House of Delegates of the Pennsylvania Medical Society convened its One Hundred and Twentieth Annual Session at 7:31 p.m., October 9, 1969, in the Marriott Motor Hotel, Philadelphia, with William Y. Rial, M.D., speaker of the house, presiding. Ulysses E. Watson, M.D., chairman, Committee on Credentials, reported that a quorum was present. The Reverend Warren C. Skipp, rector of Trinity Episcopal Church, Swarthmore, gave the invocation.

The first meeting, which continued until 10:10 p.m., included the addresses of President George E. Farrar, Jr., M.D., and President-Elect William A. Barrett, M.D.

The second meeting was convened at 9:05 a.m., October 11, 1969, at which time the elections took place and the reports of the Reference Committees on Constitution and By-laws, Education and Science, Reports of Standing and Special Committees, and Public Service were presented. No business was referred to the Reference Committee on Miscellaneous Business. The meeting recessed at 12:30 p.m. and reconvened at 1:33 p.m., at which time the reports of the Reference Committees on Reports of Officers, Governmental Relations and Medical Service were considered.

The House of Delegates approved the recommendation of the Board of Trustees and Councilors that the 1970 annual assessment remain at $75.00 for each full dues-paying active member.

The 120th Session of the House of Delegates adjourned sine die at 4:30 p.m., Saturday, October 11, 1969.

Committee on Rules

Donald E. Basom, M.D., chairman, presented the following report of the Committee on Rules, which was adopted by the House:

The Committee on Rules recommends that the business of the House be conducted in accordance with the Standing Rules of the House of Delegates as outlined on Pages 9 and 10 in this year's Official Reports Booklet.

Necrology Report

The House stood in tribute to receive the following necrology report presented by William A. Limberger, M.D., chairman of the Board of Trustees:

"At this time it is customary to ask you to give a moment's thought to our members who may have been with us here a year ago, but, in the past months, have responded to their last roll call. Their names have been memorialized in county medical soci-

cty bulletins and in PENNSYLVANIA MEDICINE, the journal of the Pennsylvania Medical Society.

"From September 1, 1968, to August 31, 1969, we have lost by death 274 members; 19 not over 50 years of age; 120 between 51 and 70; and 135 in the group aged 71 to over 90. Of these 274 members, 96 were associates, most of whom were 65 years of age or over. The necrology report at the last annual session reported the loss of 198 members.

"May we rise for this moment in silence and respect to those members who have passed to their eternal reward during the past year."

Report of the Standing Committee on Constitution and By-laws

R. Robert Tyson, M.D., chairman, referred to the report of the Standing Committee on Constitution and By-laws, as published on Page 65 of the Official Reports Booklet, and to the proposed amendments to the Constitution and By-laws contained in the "Official Call" on Pages 10-12 of the Official Reports Booklet. These materials were received as official business by the House of Delegates.

Committees of the 1969 House of Delegates

The Speaker announced that the following appointments had been made to committees of the House:

Committee on Credentials

Ulysses E. Watson, M.D., Montgomery County, chairman
John H. Hobart, M.D., Northampton County
John Y. Templeton, M.D., Philadelphia County
James L. Killius, M.D., Somerset County

Committee on Rules

Donald E. Basom, M.D., Mifflin-Juniata County, chairman
Richard J. Gill, M.D., Philadelphia County
Richard L. Huber, M.D., Lackawanna County
Raymond C. Davis, M.D., Susquehanna County
Morgan F. Taylor, M.D., Beaver County

Tellers

Philip E. Sirgany, M.D., Lackawanna County, chairman
Frank Esparragucra, M.D., Venango County
Theodore H. Mendell, M.D., Philadelphia County
Donald C. Schadt, M.D., Northampton County
Richard L. Huber, M.D., Lackawanna County
Anthony J. Cummings, M.D., Lackawanna County

Reference Committee on Constitution and By-laws

R. Robert Tyson, M.D., Philadelphia County, chairman
Paul S. Friedman, M.D., Philadelphia County
Charles P. Hammond, M.D., Lancaster County
William C. Barnett, Allegheny County

Reference Committee on Education and Science

Richard A. Kern, M.D., Philadelphia County, chairman
Robert F. Beckley, M.D., Clinton County
Edgar W. Meiser, M.D., Lancaster County
Anthony T. Merski, M.D., Erie County
Charles A. Bikle, M.D., Franklin County

Reference Committee on Governmental Relations

William C. Ryan, M.D., Somerset County, chairman
John T. McGeehan, M.D., Elk-Cameron County
Robert S. Pressman, M.D., Philadelphia County
George L. Gleeson, M.D., Dauphin County
Thomas E. Patrick, M.D., Columbia County

Reference Committee on Medical Service

Harry V. Armitage, M.D., Delaware County, chairman
Samuel D. Kron, M.D., Philadelphia County
Eugene A. Conti, M.D., Allegheny County
Donald R. Pohl, M.D., Cambria County

Reference Committee on Miscellaneous Business

Katherine R. Sturgis, M.D., Philadelphia County, chairman
M. Wilson Snyder, M.D., Mercer County
Edward T. Lis, M.D., York County

Reference Committee on Public Service

William G. Ridgway, M.D., Lancaster County, chairman
John B. Polansky, M.D., Montgomery County
William B. Birch, M.D., Greene County
Hunter S. Neal, M.D., Delaware County

Reference Committee on Reports of Officers

Robert J. Carroll, M.D., Allegheny County, chairman
William Lamberton, M.D., Erie County
Milton M. Perloff, M.D., Philadelphia County
Vorrie B. Macom, M.D., Carbon County
August A. Gabriele, M.D., York County

Reference Committee on Reports of Standing and Special Committees

William R. Davison, M.D., Cambria County, chairman
David L. Miller, M.D., Clarion County
Michael Markarian, M.D., Susquehanna County
Idilio J. Saldana, M.D., Jefferson County

Announcements by the Speaker

After introducing the members of the Board, Dr. Rial called upon William A. Limberger, M.D., chairman, to present "Supplemental Report D of the Board of Trustees and Councilors" (Copy may be obtained at PMS Headquarters), which related to the resignation of Carl B. Lechner, M.D., as president-elect because of illness. The concluding sentence of that supplemental report stated:

"For this and other reasons, the Board of Trustees recommends that the House of Delegates designate Carl B. Lechner, M.D., Honorary Past President and bestow upon him all the customary rights and privileges extended to a Past President of this Society, including that of a Past President's Medallion."

Acting as a committee of the whole, the House voted unanimously to elect Carl B. Lechner, M.D., Honorary Past President. Dr. Lechner was escorted to the rostrum where he accepted the office of Honorary Past President.

Dr. Rial announced two temporary

appointments to the Reference Committee on Constitution and By-laws: Joseph Stowell, M.D. to sit for Richard W. Skinner, M.D., and William Barnett, M.D. to sit for Frank M. Mateer, M.D.

Approval of Proceedings

The proceedings of the 119th Annual Session held in Pittsburgh, September 26-28, 1968, were approved as published in the January, 1969, issue of PENNSYLVANIA MEDICINE.

Remarks of President of Woman's Auxiliary

Mrs. Axel K. Olsen, president, Woman's Auxiliary to the Pennsylvania Medical Society, addressed the House, and her remarks (Appendix B, page 108) were referred to the Reference Committee on Standing and Special Committees.

Report of the President

George E. Farrar, Jr., M.D., president, presented a report on his year as president (published in November, 1969, PENNSYLVANIA MEDICINE). Dr. Farrar's address, except for the portions listed below, was referred to the Reference Committee on Reports of Officers.

(A) *Health Conference,* Referred to Reference Committee on Public Service

(B) *Peer Review,* Referred to Reference Committee on Medical Service

(C) *Slums,* Referred to Reference Committee on Medical Service

(D) *Continuing Medical Education,* Referred to Reference Committee on Education and Science

(E) *Allied Professions,* Referred to Reference Committee on Education and Science

(F) *Splintering,* Referred to Reference Committee on Reports of Officers

(G) *Term Limit for AMA Delegates,* Referred to Reference Committee on Reports of Officers

(H) *Popular Election of Officers of Pennsylvania Medical Society,* Referred to Reference Committee on Reports of Officers

(I) *SAMA Representation in House of Delegates,* Referred to Reference Committee on Constitution and By-laws

(J) *Health Planning,* Referred to Reference Committee on Medical Service

(K) *Advisory Committee on Health Care,* Referred to Reference Committee on Reports of Officers

(L) *Addendum, National Health Care,* Referred to the Reference Committee on Medical Service

Remarks of Carl B. Lechner, M.D.

The remarks (published in November, 1969, PENNSYLVANIA MEDICINE) prepared by Carl B. Lechner, M.D., prior to his resignation as president-elect, were distributed to members of the House and referred to the Reference Committee on Governmental Relations.

Special Election

Dr. Rial, with the permission of the House, temporarily suspended the rules so that a special election could occur to fill the vacancy in the office of president-elect. William A. Barrett, M.D., Pittsburgh, was elected president-elect by acclamation.

Remarks of the President-Elect

The remarks (Appendix A, page 105) of President-Elect William A. Barrett, M.D., were referred to the Reference Committee on Reports of Officers.

Distinguished Guests

The following distinguished guests were presented to the House:

M. Louise C. Gloeckner, M.D., vice president of the AMA.

Elmer G. Shelley, M.D., chairman, AMA Judicial Council.

Russell B. Roth, M.D., speaker, AMA House of Delegates.

William A. Sodeman, M.D., member, AMA Council on Education.

Theodore C. Bedwell, Jr., M.D., chief medical officer, bureau of health insurance, Social Security Administration.

Mrs. John M. Chenault, president, Woman's Auxiliary to the AMA.

Robert N. Smith, M.D., president, Ohio State Medical Association.

Nicholas A. Bertha, M.D., president, Medical Society of New Jersey.

Maynard P. Pride, M.D., president, The West Virginia State Medical Association.

Lucie S. Young, PhD., president, Pennsylvania Nurses Association.

Charles L. Sellars, RP, president, Pennsylvania Pharmaceutical Association.

Miss Geraldine Shunkwiler, president, Pennsylvania Association of Medical Assistants.

Robert J. Mason, M.D., president, Michigan State Medical Society.

Charles M. Moyer, M.D., president, Medical Society of Delaware.

Walter T. Heldmann, M.D., president, Medical Society of the State of New York.

Marvin Moanes, M.D., first vice president, Medical Chirurgical Faculty of Maryland.

Accepted a Telegram (Appendix F, Page 115) from Marvin Comisky, president-elect, Pennsylvania Bar Association, who was unable to attend because of illness in the family.

The following members of the Student American Medical Association were presented to the House:

Richard Shames, president, SAMA Chapter, University of Pennsylvania School of Medicine

Mark Berger, president, SAMA Chapter, Hahnemann Medical College

Ed Barylek, president, SAMA Chapter, Jefferson Medical College

Miss Lucrevia Aquino, president, SAMA Chapter, Woman's Medical College

Robert Baroff, president, SAMA Chapter, University of Pittsburgh, School of Medicine

F. Bruce Tapper, vice president, SAMA Chapter, Hahnemann Medical College

Robert Slama, president, SAMA Chapter, Temple University School of Medicine

Peter L. Andrus, vice president, SAMA Region III, University of Pennsylvania School of Medicine

Eugene Mebane, president, SAMA Chapter, Pennsylvania State University College of Medicine

Remarks of President of SAMA, Region III

Peter L. Andrus, vice president, SAMA Region III, who attends the University of Pennsylvania School of Medicine, addressed the House. His

remarks (Appendix C, Page 109) were not referred to a reference committee.

Acceptance of Reports and Resolutions

All material contained in the 1969 Official Reports Booklet, including Resolutions 69-1 through 69-31 and Supplemental Reports A, B, C, and D of the Board of Trustees and Councilors and the Supplemental Report of the Pennsylvania Delegation to the AMA were officially entered into the record of the House for deliberation and action. In addition, the following supplemental reports were accepted as official business of the House:

Report to the House of Delegates, Pennsylvania Medical Society by Allen W. Cowley, M.D., Chairman of the Board, Pennsylvania Blue Shield.

Annual Report of the Educational and Scientific Trust.

Supplemental Report of the Council on Governmental Relations.

Supplemental Report of the Committee on Aid to Education.

Report of the Committee to Nominate Delegates and Alternates to the American Medical Association.

(Copies of the above reports are available at PMS Headquarters)

Supplemental Report of the Council on Medical Service. (Appendix D, Page 111).

The following nine resolutions received after September 8, 1969, were properly accepted as business of the House of Delegates:

Resolution 69-32, "Licensed Practical Nurses," introduced by Hunter S. Neal, M.D., in behalf of the Delaware County Medical Society, referred to the Reference Committee on Education and Science.

Resolution 69-33, "Medico-Legal Protection for Ambulance Attendants," introduced by Hunter S. Neal, M.D., in behalf of the Delaware County Medical Society, referred to the Reference Committee on Governmental Relations.

Resolution 69-34, "Separate Department of Mental Health/Mental Retardation," introduced by John L. Steigerwalt, M.D., in behalf of Montgomery County Medical Society, referred to the Reference Committee on Governmental Relations.

Resolution 69-35, "Department of Mental Health/Mental Retardation," introduced by Lester A. Dunmire, M.D., in behalf of the Allegheny County Medical Society, referred to the Reference Committee on Governmental Relations.

Resolution 69-36, "Medicaid and Medicare Investigation," introduced by Raymond C. Grandon, M.D., in behalf of the Dauphin County Medical Society and referred to the Reference Committee on Medical Service.

Resolution 69-37, "Separate Department of Mental Health/Mental Retardation," introduced by Valentine R. Manning, M.D., in behalf of the Philadelphia County Medical Society, referred to the Reference Committee on Governmental Relations.

Resolution 69-38, "Adverse Publicity on Medicare and Medicaid," introduced by Lester A. Dunmire, M.D., on behalf of the Allegheny County Medical Society, referred to the Reference Committee on Medical Service.

Resolution 69-39, "Shortage of Practicing Physicians in Western Pennsylvania," introduced by Ernest L. Abernathy, M.D., in behalf of the Washington County Medical Society, referred to the Reference Committee on Public Service.

Resolution 69-40, "Radiology Services in Blue Shield," introduced by John T. McGeehan, M.D., in behalf of the Elk-Cameron County Medical Society, referred to the Reference Committee on Medical Service.

Finance Committee Report

Park M. Horton, M.D., chairman, presented the following report from the Finance Committee of the Board of Trustees and Councilors:

A copy of the proposed budget for 1970 as approved by the Board of Trustees has been distributed for your information. In addition to the 1970 figures it contains the comparative figures of the approved budget for 1969 as well as the actual expenditures incurred during the first six months of 1969.

The 1969 portion of the budget does not reflect supplemental allocations which were made as a result of action taken at the August meeting of the Board of Trustees and its meeting last night. Consequently, there are some adjustments which you may wish to make concerning the 1969 budget:

1. Account No. 200—(PENNSYLVANIA MEDICINE) The budget estimate should read: $113,821.
2. Account No. 203—(AMA Delegation) The budget estimate should read: $26,900.
3. Account No. 300—(Council on Education and Science) The figure for the control account for 1969 should be $88,395.
4. Account No. 350—(Council on Medical Service) The 1969 budget for the Council is now $41,048.
5. The total overall budget should also reflect these supplemental allocations. That means the total estimated expenses for 1969 are currently figured to be $896,278. These are the only changes in the 1969 figures.

The 1970 budget is based on the current annual assessment. You will note that the budget for 1970 anticipates a surplus of $21,532. Were it not for the reimbursement that the Society receives for administrative services rendered to the Susquehanna Valley Regional Medical Program, which is estimated at $66,496 in 1970, the budget would show a deficit of $44,964. Because the figure for reimbursement is only an estimate and because government funds are subject to the will of Congress and political developments, the Finance Committee considers the budget to be on somewhat tenuous ground. If the reimbursement was withdrawn, your Finance Committee would likely be forced to recommend an increase in the dues.

Recommendations which may arise from the reference committees could change quickly the complexion of the hoped-for surplus. Please bear in mind that nearly every recommendation for a new or expanded project which you adopt can be expected to cost money to implement.

The Finance Committee plans to note and evaluate for budgetary purposes any new programs which you approve and to present its recommendations for dues for 1970 at the final session of the House.

If there are any questions regarding the budget or the financial condition of the Pennsylvania Medical

Society, please attend the hearing of the Reference Committee on Reports of Officers. Members of the Finance Committee will be available to hear opinions and will attempt to answer any questions which arise.

Committee to Nominate Delegates and Alternates to the American Medical Association

Daniel H. Bee, M.D., presented the following report of the committee:

The Committee to Nominate Delegates and Alternates to the American Medical Association reviewed the actions and reports of the Pennsylvania Delegation to the American Medical Association and wishes to express, on behalf of the entire House, our appreciation for dedicated service. We feel that the Pennsylvania Delegation within the American Medical Association maintains its superior stature due to the untiring efforts of these physicians.

With regret we report the retirement, as a delegate, of Edward Lyon, Jr., M.D., of Lycoming County, who served twelve years as an alternate and ten years as a delegate. Our committee would ask the House to give an especial thanks to this gentleman for his long and faithful service.

A second vacancy occurs on the delegation due to the death of W. Benson Harer, M.D., who served the delegation from January 1, 1960, until October 11, 1968.

In its position and from its mandate from the House, the Committee to Nominate Delegates and Alternates to the American Medical Association, after long and careful thought, decided not to place in nomination the name of Wendell B. Gordon, M.D., of Allegheny County. This was not due for any reason having to do with the long and faithful service that he gave this House, but for reasons that the Committee felt that it was possible to make a delegation that was somewhat more effective by this change. Therefore, the Committee nominates as delegates to the American Medical Association from Pennsylvania for two-year terms commencing January 1, 1970, the following member physicians:

Raymond C. Grandon, M.D., Dauphin County
Samuel B. Hadden, M.D., Philadelphia County
John B. Lovette, M.D., Cambria County
Thomas W. McCreary, Sr., M.D., Beaver County
Malcolm W. Miller, M.D., Philadelphia County
Russell B. Roth, M.D., Erie County

As alternate delegates to the American Medical Association for two-year terms beginning on January 1, 1970, the committee nominates the following:

Wilbur E. Flannery, M.D., Lawrence County
Paul S. Friedman, M.D., Philadelphia County
John F. Hartman, Jr., M.D., Erie County
Carl B. Lechner, M.D., Erie County
Matthew Marshall, Jr., M.D., Allegheny County
David S. Masland, M.D., Cumberland County

Three alternate delegates whose terms expire December 31, 1970, are being nominated as delegates for two-year terms. In the event that these nominees are elected as delegates, the committee wishes to nominate the following members of the Society to fill the unexpired terms of Drs. Grandon, Lovette, and Miller, as alternate delegates to serve from January 1, 1970, to December 31, 1970:

R. William Alexander, M.D., Berks County
Robert F. Beckley, M.D., Clinton County
R. Robert Tyson, M.D., Philadelphia County

Respectfully submitted,
Edgar W. Meiser, M.D.
John B. Montgomery, M.D.
Daniel H. Bee, M.D., chairman

The opening Session of the House adjourned at 10:10 p.m.

Second Session of the House
October 11, 1969

The second session of the House of Delegates was called to order in the Brandywine Ballroom of the Marriott Motor Hotel, Philadelphia, October 11, 1969 at 9:05 a.m. The Credentials Committee reported that a quorum was present.

PaMPAC
Presentation

William B. West, M.D., chairman of the PaMPAC Board of Directors, presented an informational report to the House. Dr. West's report included the presentation of an honorary life membership in PaMPAC to Stephen J. Deichelmann, M.D., Montgomery County, one of the original five men who started medical political action in Pennsylvania. (Appendix E, Page 113).

Report of the Reference Committee on Constitution and By-laws

R. Robert Tyson, M.D., chairman, presented the following report of the Committee which was adopted by the House:

Report of the Committee to Study Relations between Medicine and Osteopathy. (Pages 74-75 of the Official Reports Booklet)

In considering the proposed amendments to the Constitution and By-laws which would permit qualified doctors of osteopathy to become Society members, we carefully reviewed the report of the Special Committee to Study Relations between Medicine and Osteopathy. That report included references to a recent action by the Pennsylvania State Board of Medical Education and Licensure which advised that:

> "Graduates of colleges of osteopathy (The colleges tacitly being approved by this Board) will be admitted to rotating internships within the Commonwealth providing they make application within five years of the date of graduation. Upon satisfactory completion of the rotating internship, they may apply for approved residency training in the various disciplines currently approved by the AMA."

We wish to commend the special committee for its succinct but comprehensive report. We also wish to commend the State Board of Medical Education and Licensure for its perception in opening the door of traditional clinical medical education to osteopathy. We found this report of considerable help in our consideration of the proposed amendments concerning osteopaths.

I move adoption of this portion of the reference committee report.

Proposed amendments to Constitution and By-laws to permit qualified doctors of osteopathy to become Society members; and clarification of affiliate membership provisions. (Official Reports Booklet, pages 10-11)

In considering the question of revising the Constitution and By-laws so that osteopaths might be admitted to membership, we noted several signifi-

cant actions by the House of Delegates of the AMA. The first occurred at the Clinical Convention in December, 1968, when the following statement of objectives was adopted:

"The American Medical Association seeks to: (1) Assure the provision of the best possible health care to the American people; (2) Make available to students and graduates in osteopathy, education of the same high standards as prevail in undergraduate, graduate, and continuing educational programs in medicine; and (3) Provide avenues whereby qualified osteopaths may be assimilated into the main stream of medicine."

At the same December, 1968, meeting, the AMA House of Delegates adopted a plan for attaining the above objectives. One provision of the plan stated:

"The American Medical Association suggests that each county and state medical society may accept qualified osteopaths as active members and thereby provide for their membership in the American Medical Association."

Then, at its 118th Annual Convention in New York City, July 13-17, 1969, the House of Delegates of the AMA amended the first paragraph of Chapter I, Section 1 of the AMA By-laws as follows:

(A) "Regular Members—Regular membership shall be limited to those members of a state medical association who hold the degree of doctor of medicine or bachelor of medicine, or who hold an unrestricted license to practice medicine and surgery, and are entitled to exercise the rights of membership in their state medical associations, including the right to vote and hold office, as determined by their state medical associations."

We acknowledge these significant actions by the AMA House and wish to report that they set the foundation for the testimony heard by your committee on this subject. There was no opposition heard to the concept of permitting the admission of osteopathic physicians to membership in county medical societies and in turn the State Society and AMA. All clearly understood that this change in the Constitution and By-laws is permissive in that it paves the way for each county society to take whatever action it may desire with regard to admission of osteopathic physicians.

We recognize that many of the specialty examining boards do not admit osteopaths for examination. We are also cognizant of the many hurdles to be overcome before a truly meaningful relationship between the families of organized medicine and osteopathy can occur. We wish to emphasize the importance of continued effort by both parties to achieve the cooperation needed to produce the best possible medical care for our citizens.

In view of the ultimate benefits for patients everywhere, we recommend the adoption of the proposed amendments of the Standing Committee on Constitution and By-laws, which would permit membership by qualified osteopaths; however, as was pointed out in the reference committee hearing, in Article IV, Section 1 of the Constitution and Chapter 1, Section 1 of the By-laws the words, "doctor of medicine, a bachelor of medicine, a doctor of osteopathy, or other" are superfluous. We recommend that the proposed amendment to Article IV, Section 1 of the Constitution be amended to read as follows:

"As used in this Constitution, except as otherwise herein expressly qualified, the term 'physician' means a person holding an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania."

and that

Chapter I, Section 1 of the By-laws be amended to read as follows:

"In conformity with the Constitution of this Society the term 'physician' as used in these By-laws, except as otherwise expressly qualified in the Constitution in any particular related provision, means a person holding an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania."

I move that the amendments to the proposed amendments of Article IV, Section 1 of the Constitution and Chapter I, Section 1, of the By-laws be adopted.

Before moving adoption of the amendments concerning osteopaths, we wish to call attention to the need for a correction in Article IV, Section 5, Sub-Section b of the Constitution. We wish to report briefly on this correction at this time as it occurs in a section of the Constitution affected by the osteopathic amendments; ideally both changes should be made at once. The correction is explained in the report of the Standing Committee on Constitution and By-laws, found on Page 66 of the Official Reports Booklet.

I move that the amendments to the Constitution and By-laws relating to membership provisions to permit qualified doctors of osteopathy to become Society members; and clarification of affiliate membership provisions be adopted as amended.

Resolution 69-12: Membership for osteopathic physicians. (Page 127 of the Official Reports Booklet)

We considered 69-12 along with other materials pertaining to the proposed amendments to the Constitution and By-laws permitting osteopathic physicians to become members of the State Society. We believe the previous changes in the Constitution and By-laws if approved accomplish this purpose. We endorse the sentiments expressed in Resolution No. 69-12, the resolve portion of which reads:

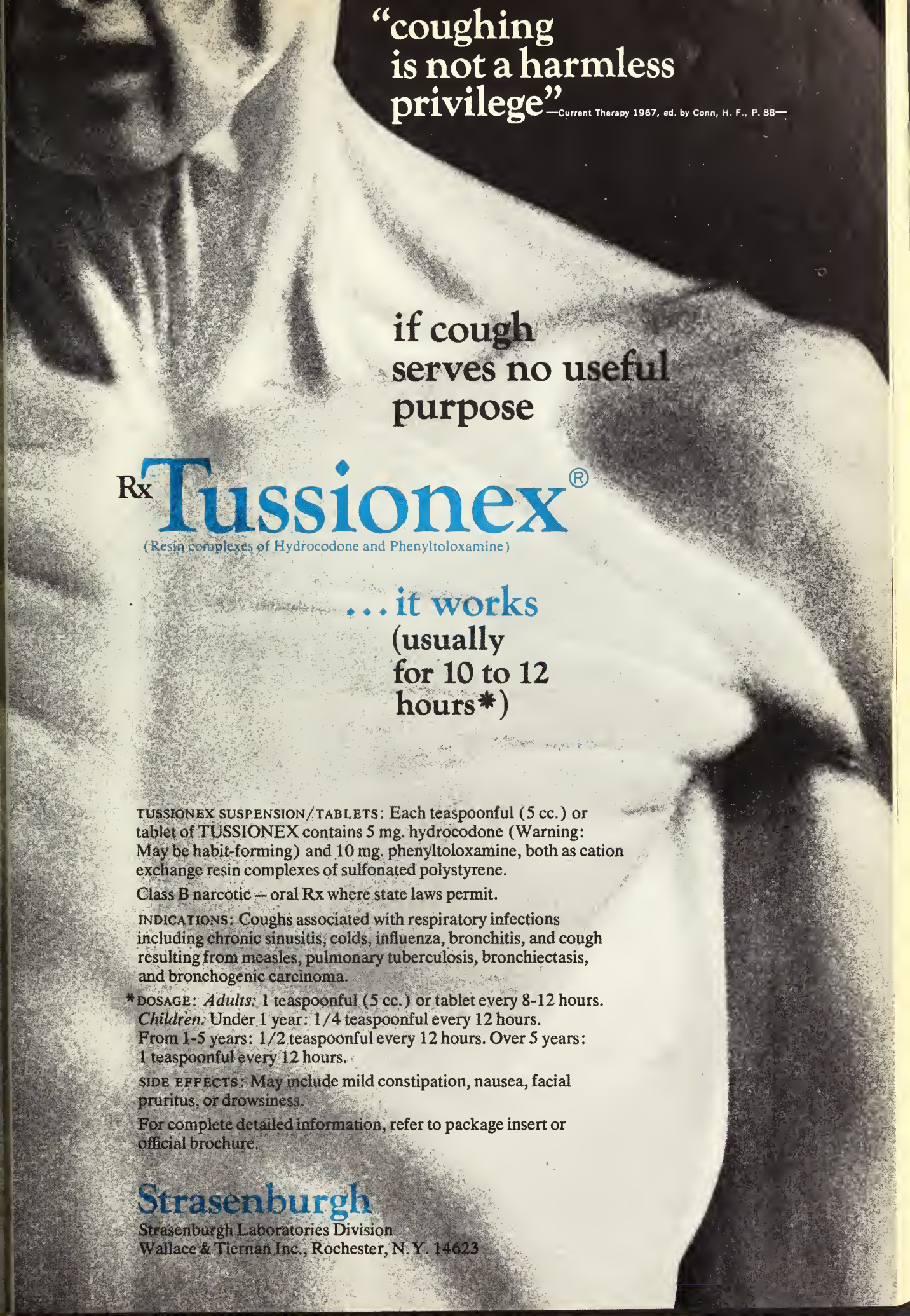
"RESOLVED, That the category of active membership in the Pennsylvania Medical Society be expanded to include osteopathic physicians who have been approved for membership by an appropriate committee of a component county medical society."

I move the adoption of Resolution No. 69-12 as printed on Page 127 of the Official Reports Booklet.

Proposed clarification of By-laws provisions regulating reinstatement of a member who is delinquent in paying his annual assessment. (Page 11 of the Official Reports Booklet)

We note with interest the practice of the Berks County Medical Society in requiring approval of the County Board of Censors before a delinquent member is reinstated to good standing. Because such a procedure reflects favorably on organized medicine's determination to keep order in its own house, we view with approval this procedure.

We find that the use of the word "automatically" in the By-laws of the State Society serves no significant purpose in relation to the reinstatement of delinquent members. Indeed, reinstatement of the delinquent member by his County Society should be the key to his return to good standing in



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Class B narcotic – oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

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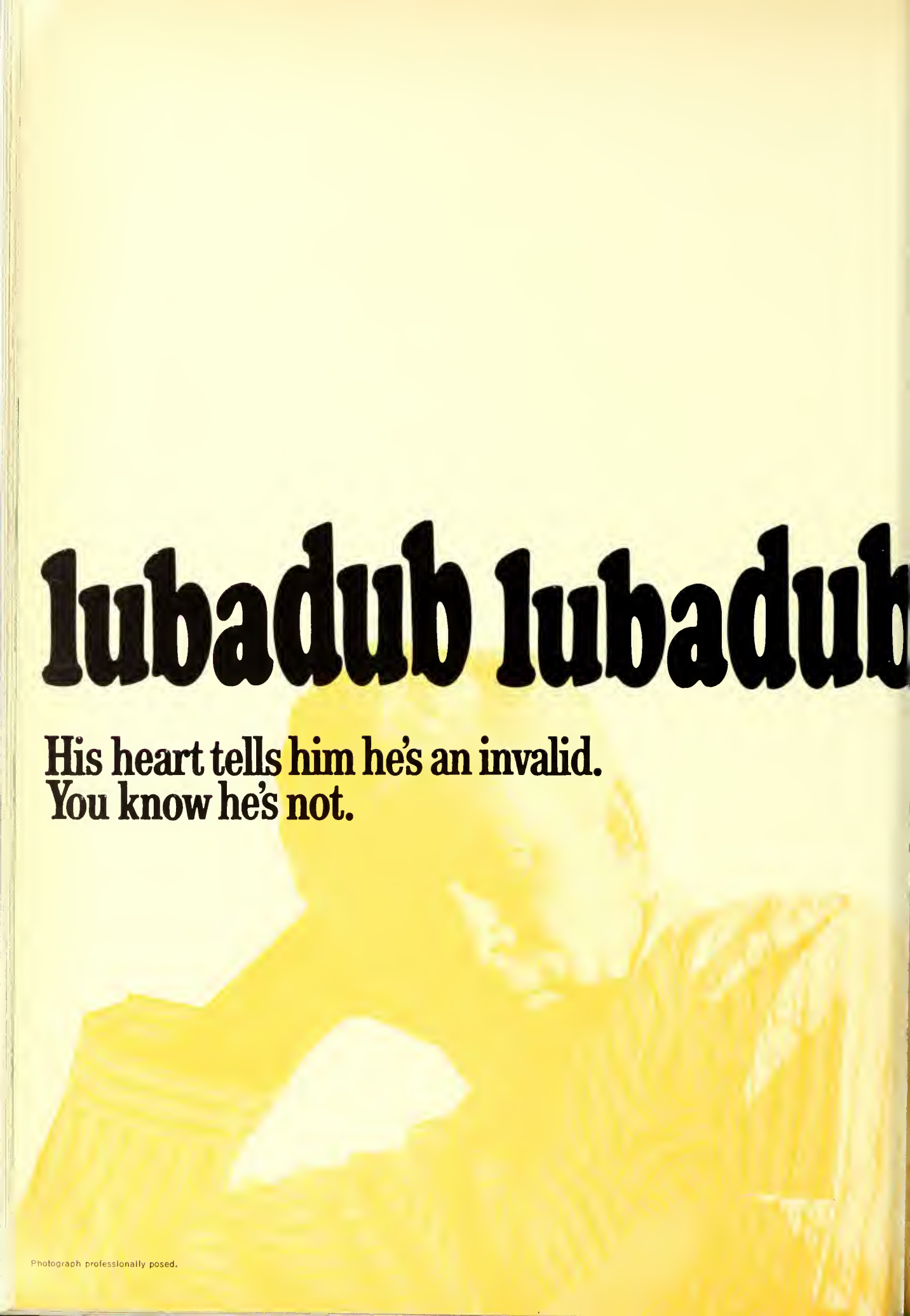

Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

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Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

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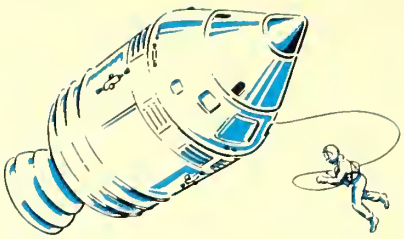

Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

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Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

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the State Society. Consequently, we recommend approval of these proposed amendments.

I move that the proposed amendments to the By-laws regarding reinstatement of delinquent members be adopted as printed on Page 11 of the Official Reports Booklet.

Proposed amendments to the Constitution and By-laws which would provide the president of each SAMA chapter in Pennsylvania with a seat in the House of Delegates, including the right to vote, serve on reference committees, and introduce resolutions. (Page 11 of the Official Reports Booklet)

That portion of the Standing Committee's report which refers to these amendments is found on Page 67 of the Official Reports Booklet. We heard extensive testimony in favor of this proposal and believe that involvement of young physicians in the work of county and state medical societies is imperative, and that giving Pennsylvania SAMA chapters official representation in the House is an effective means of encouraging this participation.

Because representation without responsibility is meaningless, we recommend that the right to vote accompany such representation; consequently, we urge adoption of the proposed amendments to the Constitution and By-laws giving each Pennsylvania SAMA Chapter representation in the House.

I move the adoption of the proposed amendments to the Constitution and By-laws providing the President of each SAMA Chapter in Pennsylvania with a seat in the House of Delegates, including the right to vote, serve on Reference Committees and introduce resolutions. These amendments affecting Articles IV and VI of the Constitution and Chapter III of the By-laws, are found on Page 12 of the Official Reports Booklet.

Comments of the President regarding SAMA representation in the House of Delegates. (Published in November, 1969 PENNSYLVANIA MEDICINE)

We have given careful consideration to the comments of President Farrar concerning SAMA representation in the House of Delegates and his transmittal of the proposal of Peter L. Andrus, vice president, SAMA Region III. This proposal called for proportional representation in the ratio of one delegate for each 100, or fraction thereof, of active members in good standing of SAMA.

We heard no testimony in support of this. We believe that our previous recommendations are the most appropriate means of providing SAMA with representation.

I move the adoption of this portion of the Reference Committee Report.

Report of the Standing Committee on Constitution and By-laws. (Official Reports Booklet, Pages 65-67)

I move the adoption of this portion of the Reference Committee Report.

Elections

Elections were held on Saturday, October 11, 1969. The following officers were elected:

President-Elect: William A. Limberger, M.D., Chester County
First Vice-President: Charles K. Rose, Jr., M.D., Lehigh County
Second Vice-President: Charles A. Bikle, M.D., Franklin County
Third Vice-President: Orlo G. McCoy, M.D., Bradford County
Fourth Vice-President: Edward T. Lis, M.D., York County
Secretary: Raymond C. Grandon, M.D., Dauphin County
Speaker, House of Delegates: William Y. Rial, M.D., Delaware County
Vice-Speaker, House of Delegates: John B. Lovette, M.D., Cambria County
Trustee and Councilor, First District: A. Reynolds Crane, M.D., Philadelphia County
Trustee and Councilor, Second District: LeRoy A. Gehris, M.D., Berks County
Trustee and Councilor, Sixth District: H. Thompson Dale, M.D., Centre County
Trustee and Councilor, Eighth District: David J. Keck, M.D., Erie County

The following were elected as Delegates to the American Medical Association for a term of two years (from January 1, 1970, to December 31, 1971):

Wendell B. Gordon, M.D., Allegheny County
Samuel B. Hadden, M.D., Philadelphia County
John B. Lovette, M.D., Cambria County
Thomas W. McCreary, Sr., M.D., Beaver County
Malcolm W. Miller, M.D., Philadelphia County
Russell B. Roth, M.D., Erie County

The following were elected as alternate delegates to the American Medical Association for a term of two years (From January 1, 1970, to December 31, 1971):

Wilbur E. Flannery, M.D., Lawrence County
Paul S. Friedman, M.D., Philadelphia County
John F. Hartman, Jr., M.D., Erie County
Carl B. Lechner, M.D., Erie County
Matthew Marshall, Jr., M.D., Allegheny County
David S. Masland, M.D., Cumberland County

The following were also elected as Alternates to the AMA (terms expire December 31, 1970):

R. William Alexander, M.D., Berks County
R. Robert Tyson, M.D., Philadelphia County

The Speaker ruled as in 1968, that a valid ballot to elect delegates to the AMA must contain six of the eight names nominated.

Edmund L. Housel, M.D., Philadelphia County, agreed to abide by the ruling of the chair, but wished to voice his objection. For clarification the Speaker called upon Legal Counsel, Mr. C. Grove McCown, to speak to the matter of what would constitute a properly executed ballot. He confirmed the speaker's ruling.

The roll was read by Secretary Allen W. Cowley, M.D., Dauphin County.

Others elected were as follows:

Committee to Nominate Delegates and Alternates to the AMA:
John B. Montgomery, M.D., Philadelphia County (three-year term)

Judicial Council:
William F. Brennan, M.D., Allegheny County (five-year term)

District Censors:
Adams, James H. Allison; Allegheny, Robert A. Schein; Armstrong, Arthur R. Wilson; Beaver, Herman Bush; Bedford, Graffious L. Rinard; Berks, Ethan L. Trexler, Blair, John W. Hurst; Bradford, Willis Redding; Bucks, Stanley F. Peters; Butler, William R. Fitzsimmons; Cambria, Warren

F. White; Carbon, James M. Steele; Centre, H. Richard Ishler; Chester, Irving M. Waggoner; Clarion, Theodore R. Koenig; Clearfield, Fred Pease; Clinton, John P. Brandt; Columbia, G. Paul Moser; Crawford, David D. Kirkpatrick, Jr.; Cumberland, Hans S. Roe; Dauphin, Hamblen C. Eaton; Delaware, Edward G. Torrance; Elk-Cameron, James L. Hackett, Sr.; Erie, Joseph M. Faso; Fayette, Othello S. Kough; Franklin, Albert W. Freeman; Greene, William W. Bartholomew; Huntingdon, Frederic H. Steele; Indiana, Robert G. Goldstrohm; Jefferson, Franklin S. Bizousky; Lackawanna, John C. Sanner; Lancaster, William A. Atlee; Lawrence, Gerald H. Weiner; Lebanon, C. Ray Bell, Jr.; Lehigh, Frederick R. Bausch, Jr.; Luzerne, Donald F. Closterman; Lycoming, Wilfred W. Wilcox; McKean, Ralph E. Hockenberry; Mercer, Robert W. Monroe; Mifflin-Juniata, John R. W. Hunter, Jr.; Monroe, Claus G. Jordan; Montgomery, Rudolph K. Glocker; Montour, Isaac L. Messmore; Northampton, Walter J. Filipek; Northumberland, J. Mostyn Davis, Jr.; Perry, William Magill; Philadelphia, Charles M. Thompson; Potter, Herman C. Mosch; Schuylkill, Joseph T. Marconis; Somerset, Alexander Solosko; Susquehanna, Raymond C. Davis; Tioga, James W. Montague; Union, John S. Purnell, Sr.; Venango, Roland H. Corbet; Warren, Robert D. Donaldson; Washington, Herbert J. Levin; Wayne-Pike, Hobart N. Owens; Westmoreland, Leslie S. Pierce; Wyoming, John S. Rinehimer, Jr.; York, William C. Langston.

Report of the Reference Committee on Education and Science

Richard A. Kern, M.D., chairman, presented the following report of the committee, which was adopted by the House.

Reports of Officers, Trustees and Councilors: portion on Continuing Education (Official Reports Booklet, pages 23-24)

The reference committee notes with satisfaction the several constructive actions of the Board of Trustees and Councilors during the year in support of the Council on Education and Science. Thanks to this support, the Council was able to expand its activities and to make significant progress in its educational programs.

Report of the Councilor for the Seventh District: portion on Continuing Medical Education (Official Reports Booklet, page 53)

The Councilor calls attention to the need for bringing programs of continuing medical education to physicians in less populous areas, and particularly for the decentralized systematic approach by the Council on Education and Science to provide knowledge in specialty fields. He will find the report of that Council in full harmony with his several suggestions for meeting the requirements of his district.

Report of the Committee on Objectives: portion on Periodic Relicensure for Physicians (Official Reports Booklet, pages 70-71)

The suggestions made in 1968 by Dr. Farrar, recommending that thought be given to the possibility of periodic relicensure for physicians and of requirement of educational credits for continuation of membership in this Society, were referred to the Committee on Objectives.

This reference committee agrees with the conclusions of the Committee on Objectives, favoring a gradual approach to the subject, beginning with a more effective voluntary continuing education program, and then, if relicensure be deemed necessary, that it be based on educational credits, rather than on challenge examination; and further, that the subject be continued under study by the Council on Education and Science.

Address of the President: Continuing Education (Published in November, 1969 PENNSYLVANIA MEDICINE)

Your reference committee at this point calls attention, and with its full approval, to the paragraph on Continuing Medical Education in the address of President Farrar, recommending that the Pennsylvania Medical Society request each member to qualify for the American Medical Association Physician Recognition Award, involving 150 hours of continuing education in every three years. Such a program, in addition to its educational objective, has the further advantage of uniformity of procedure that should recommend it to other state medical societies.

I move the adoption of this portion of the Reference Committee Report.

Report of the Council on Education and Science (Official Reports Booklet, pages 112-123)

The ever-increasing speed with which new medical knowledge is accumulating calls for a correspondingly increased pace of continuing medical education. The report of the Council on Education and Science is an imposing record of the activities of that Council and of its commissions and committees in keeping up with that accelerated pace, using new approaches to old and new problems and with constructive suggestions for envisioned future needs.

The Council reports its actions, and those of its commissions, pursuant to eleven resolutions adopted by the House of Delegates in 1968, to implement and carry out their purpose and intent.

The report also lists fifteen additional projects, covering a wide range of educational and scientific programs, some carried out under the aegis of the Council itself, some in cooperation with various groups and organizations. We resist the temptation to applaud all of them singly, but are particularly impressed with the fine efforts to bring continuing education to isolated areas. We highly commend the community hospital courses which are being developed and expanded, including the checks and balances on their needs and effectiveness.

The reports of the five commissions of the Council were reviewed, and the reference committee supports their several interests and activities. We make special mention of a few: the cooperation of the Commission on Environmental Health with the International Joint Commission to curb Great Lakes pollution; the regional faculties in geriatric training under the Commission on Geriatrics, and the position statement on hypnosis prepared by the Commission on Mental Health and Mental Retardation. Your reference committee recommends the approval of the position statement on hypnosis by the House of Delegates.

I move the adoption of this portion of the Reference Committee report.

We note the appointment by the Council, from among its own members, of three advisory committees: on emergency medical service, on manpower, and on scientific session. Their several sections of the report have been reviewed by this reference committee, which is in accord with their activities and recommendations. In this regard, we note that the section of the report dealing with emergency medical service includes a positive recommendation on the training of ambulance personnel in keeping with Resolution No. 69-10.

The Advisory Committee on Manpower mentions the growing need for more highly specialized paramedical personnel, and the training and use of such personnel. In this connection, the reference committee has considered and approved in principle Paragraph E, page 8, Allied Professions, referred to it from the *Address of the President,* who recommends that the Council on Education and Science continue efforts to increase and better utilize allied health professionals, including a demonstration project of utilizing such personnel under physician guidance in areas now with insufficient health personnel.

I move the adoption of this portion of the Reference Committee Report.

Of particular significance is the report of the Advisory Committee on Scientific Session. That committee recorded its conclusion that the annual scientific session is no longer an effective method of continuing medical education for the members of the Pennsylvania Medical Society in view of the steadily diminishing attendance at the annual scientific session reaching a low of 154 members who in 1968 paid a registration fee.

The Council on Education and Science reached the same conclusion as its advisory committee, and therefore proposed the substitution of an educational institute for the annual scientific session. The Council further stated that, since 90 per cent of the educational activities can and should be structured within the local hospitals, this institute would be in the province of hospital-based educators. Both the Council and its advisory committee were ready to counsel the dropping of the annual scientific session.

The surprisingly good record of the annual scientific session last month has sharply modified the view of the Council and its advisory committee. The attendance of members who paid registration fees reached 434, or almost three times as many as a year ago. Moreover, those attendees all favored the continuance of a similar type of program in the future. The success of this session was undoubtedly furthered by the inclusion of the specialty groups and their sharing in the support of the meeting through registration fees. The continuance of the nursing segment of the program was another favorable influence.

Your reference committee concurs with the suggestions made to it by Council and advisory committee members, that the annual scientific session for 1970 be planned along similar lines. Your reference committee further offers the thought that such planning include participation in the program by other health personnel groups as may seem desirable. Your reference committee also hopes that thought will be given to the inclusion of scientific exhibits in the session. It is pointed out that 15 of the 225 scientific exhibits at this year's session of the American Medical Association originated in Pennsylvania hospitals, schools and clinics, and that even more could be attracted to our sessions.

The proposal for institutes is favorably received by your reference committee as an important part of the larger program of the several aspects of continuing medical education. The time is now ripe for the formulation, in greater detail, by the Council on Education and Science, including data on costs, methods of financing and teacher staffing, including the addition to the staff of a professional medical educator. Your reference committee recommends that the Council on Education and Science proceed in such formulation, supported by consultations with the Board of Trustees and Councilors, to the end that that Board may take considered action. The reference committee expresses its high commendation to the Council on Education and Science, its commissions and its advisory committees for their informative reports and attention to referred items, and particularly for their farsighted and constructive plans for the future.

I move acceptance of this portion of the Reference Committee Report.

Resolution No. 69-8: Reporting of Conditions Leading to Safety Hazards (Official Reports Booklet, page 126)

WHEREAS, Physicians are being called upon more and more to approve the physical condition of individuals and assess their capacity to function in a safe manner; and

WHEREAS, This is more evident in the driver examination program in Pennsylvania and in the certifying examination prescribed by the Federal Aviation Administration; and

WHEREAS, Legislation has been in force for some time requiring physicians to report gunshot wounds and conditions which would be indicative of child abuse; and

WHEREAS, Physicians from time to time see patients involved in occupations involving the safety of others; and

WHEREAS, In the examination of these individuals, conditions may come to light, which in the opinion of the physician could create a hazard for those individuals whose safety depends upon the patient; therefore be it

Resolved, That the Pennsylvania Medical Society seek legislation which will permit physicians to report conditions which in their opinion would adversely affect the patient's normal occupational function.

Your Reference Committee considers favorably the intent of this resolution. However, it does involve obvious legal implications that must be carefully considered.

The Reference Committee therefore recommends that Resolution No. 69-8 be referred to the Board of Trustees and Councilors for consultation with legal counsel.

Resolution No. 69-10: Education for Ambulance Personnel (Official Reports Booklet, page 126)

WHEREAS, The need for transportation of the ill and injured will increase as our present medical system drifts toward centralization; and

WHEREAS, All ambulances should carry updated practical medical equipment and the attendants should be instructed in current first aid procedures as recommended by the National Academy of Sciences —National Research Council; and

WHEREAS, Many ambulance personnel appear eager for more training when it is arranged and presented; and

WHEREAS, Most past instructors for ambulance personnel have been individual interested physicians; and

WHEREAS, Present and future ambulance instruction programs can conceivably include the starting of infusions; and

WHEREAS, There is a necessity for study and discussion of the legal problems involved in instructing ambulance attendants on an annual basis; therefore be it

Resolved, That the Pennsylvania Medical Society encourage all county medical societies to assume the responsibility of helping update the first aid instruction of all ambulance attendants operating in their area on an annual basis.

Your Reference Committee concurs with the objectives of the resolution.

I move the adoption of Resolution No. 69-10.

Resolution No. 69-21: Support of Practical Nursing (Official Reports Booklet, page 129-130)

WHEREAS, Licensed practical nurses are prepared within a carefully structured educational program; and

WHEREAS, Schools of practical nursing must be inspected and subsequently approved by a state board legally authorized to issue such approval in every state and territory of the United States; and

WHEREAS, Graduates of schools of practical nursing throughout the country are required to take state board examinations to measure their competency; and

WHEREAS, Upon successful completion of such examinations, licenses to practice are issued to graduates of schools of practical nursing; and

WHEREAS, Licensed practical nurses are recognized by United States physicians as reliable and competent paramedical personnel; therefore be it

Resolved, That the Pennsylvania Medical Society lend every support to the cause of practical (vocational) nursing, to licensed practical nurses, and to the schools and faculties that prepare them in the Commonwealth of Pennsylvania.

Your Reference Committee is in agreement with the intent of this resolution. We call attention, however, to the fact that the American Medical Association, at its Annual Session in July of this year, reaffirmed its existing policy of the support of all nurses' training programs, including specifically practical nurses' training. Therefore, your Committee believes the second resolve to be unnecessary.

I move the adoption of Resolution No. 69-21 as amended.

Resolution No. 69-32: Licensed Practical Nurses (Delegates' Packet)

WHEREAS, Licensed practical nurses are prepared within a carefully structured educational program; and

WHEREAS, Schools of practical nursing must be inspected and subsequently approved by a State board legally authorized to issue such approval in Pennsylvania; and

WHEREAS, Graduates of schools of practical nursing throughout Pennsylvania sit for an examination which measures their competency and upon the successful completion of which they are issued a legal license to practice; and

WHEREAS, Licensed practical nurses are recognized by the physicians of Pennsylvania as a reliable and competent source of sound patient care; therefore be it

Resolved, That the Pennsylvania Medical Society lend every support to the cause of practical nursing and to licensed practical nurses and to the schools and faculties that prepare them in the Commonwealth of Pennsylvania.

This resolution is similar in substance and intent to Resolution No. 69-21.

I move the adoption of Resolution No. 69-32.

Resolution No. 69-22: Family Practice (Official Reports Booklet, page 130)

WHEREAS, There is pressing need to increase the number of physicians in general practice; and

WHEREAS, It is unlikely that medical students will choose this area of practice unless they are familiarized with it in the course of their medical studies; therefore be it

Resolved, That the Pennsylvania Medical Society undertake the promotion of departments of family practice in Pennsylvania medical schools by seeking financial support for them through the Commonwealth of Pennsylvania and other appropriate sources; and be it further

Resolved, That the Pennsylvania Medical Society establish undergraduate grants-in-aid for student preceptorships under family doctors; and be it further

Resolved, That the Pennsylvania Medical Society seek financial aid in establishing opportunities for graduate training in the field of family practice through internships, residencies, and fellowships, particularly for training physicians as medical educators in the context of family practice.

Your Reference Committee is in full sympathy with the principle of promotion of teaching and training opportunities for increasing the number of physicians in general or family practice. That principle has been abundantly confirmed by the Pennsylvania Medical Society in the past. Your Reference Committee, however, does not feel that the Pennsylvania Medical Society should be required to finance or seek financial aid for such promotion of any specialty group.

Your Reference Committee therefore recommends that Resolution No. 69-22 be *not* approved. (The House agreed with the Reference Committee and the Resolution lost)

Resolution No. 69-23: Acute Alcoholism (Official Reports Booklet, page 130)

Your Reference Committee is in agreement with the intent of this resolution. However, there is in existence a division of alcoholism studies and rehabilitation in the Pennsylvania Department of Health. Therefore, the third resolved becomes unnecessary and should be deleted. The intent of the resolution will be strengthened by amending the second resolved to read:

Resolved, That in addition to developing detoxification centers for the care of acute and chronic

alcoholics, communities and the appropriate Pennsylvania health agencies should be encouraged to develop rehabilitation centers.

As amended, Resolution 69-23 reads:

WHEREAS, Alcoholism is a serious public health problem; and

WHEREAS, It is estimated that there are seven million persons, or 5 per cent of the adult population, suffering with alcoholism in the United States; and

WHEREAS, The National Safety Council indicates that alcohol is a factor in more than 50 per cent of fatal motor collisions and in a high percentage of industrial accidents; and

WHEREAS, Many communities lack adequate facilities for the care of alcoholics; therefore be it

Resolved, That the Pennsylvania Medical Society continue its efforts toward encouraging all community hospitals to meet the medical needs of acute alcoholics; and be it further

Resolved, That in addition to developing detoxification centers for the care of acute and chronic alcoholics, communities and the appropriate Pennsylvania health agencies should be encouraged to develop rehabilitation centers.

I move the adoption of Resolution No. 69-23 as amended.

Your reference committee appreciates the interest shown and help given by physicians in the open hearing before the committee and by physicians and others before the hearings.

Report of Reference Committee on Reports of Standing and Special Committees

William R. Davison, M.D., chairman, presented the following report of the committee, which was adopted by the House:

Advisory Committee to the Woman's Auxiliary (Official Reports Booklet, page 64)

Your reference committee reviewed the above report and notes with interest the activities of the Woman's Auxiliary during the past year. We commend the auxiliary's activities in health careers, community health projects, and public health education.

I move the adoption of this portion of the Reference Committee report.

Committee on Relationships with Allied Professions (Official Reports Booklet, page 67)

Your reference committee commends the success of the state-wide physician/nurse seminars and recommends stronger physician support of these meetings. This committee recommends liaison with the state organization of licensed practical nurses, recognizing them as part of the nursing profession. We also commend the committee for its liaison with the various organizations listed in their report and urge them to enlarge upon it where advisable.

I move the adoption of this portion of the reference committee report.

Committee on Medical Benevolence (Official Reports Booklet, page 68)

Your reference committee commends the committee for its work in the field of medical benevolence and recommends the approval of its recommendation for continuation of the $1.00 allotment per active member in 1970.

The reference committee believes that physicians should recognize this as one of the many benefits of membership in the State Medical Society.

I move the adoption of this portion of the reference committee report.

Committee on Objectives (Official Reports Booklet, page 69)

Your reference committee appreciates the abstract and philosophical nature of the assignment and commends the conclusions and recommendations of this report. We recognize the importance of continuing the work of this committee in long range planning to provide leadership in the health field.

I move the adoption of this portion of the reference committee report.

Committee on Discipline (Official Reports Booklet, page 73)

Your reference committee notes the relative inactivity of the committee which may indicate that these matters are being handled on the county level. The reference committee urges the county medical societies to cooperate in the survey of the activities of the grievance committees, as mentioned in this committee's report. This will assist them in determining how complaints are being handled at the county level.

I move the adoption of this portion of the reference committee report.

Committee on Medicine and Religion (Official Reports Booklet, page 75)

Your reference committee notes with approval the increasing liaison between clergymen and physicians in ministering to the "whole man."

We look with favor upon the Board of Trustees' action declaring March, 1970, as Medicine and Religion Month.

I move the adoption of this portion of the reference committee report.

Committee on General Practice (Official Reports Booklet, page 77)

Your reference committee recognizes the problems involved in the delivery of health care in those areas both urban and rural lacking adequate medical coverage.

We will note with interest the results of the pilot study being made in Perry County. We recommend, however, the exploration of alternative methods of providing medical coverage for these areas such as increased family practice residencies, satellite clinics and regional dispensaries.

While we concur with the recommendations of the committee for provision of low interest construction and equipment loans and financial assistance to medical schools for education of students, by the federal government, we recommend other avenues also be explored for financing these ideas. The committee also believes that any means of establishing better contact between organized medicine and medical students should be pursued.

I move the adoption of this portion of the reference committee report.

Resolution 69-29: Liaison with the Pennsylvania Podiatry Association (Official Reports Booklet, page 132)

WHEREAS, The Pennsylvania Podiatry Association has exhibited a sincere interest and dedication to professional and high quality health care of the patient; and

WHEREAS, The Joint Commission for the Accreditation of Hospitals has established guidelines for

hospital privileges of podiatry practice (JCAH Bulletin 44, April 1967); and

WHEREAS, The Pennsylvania Medical Society and the Pennsylvania Podiatry Association are concerned that the quality of health care be continued at highest levels; therefore be it

Resolved, That the Pennsylvania Medical Society and the Pennsylvania Podiatry Association establish a joint liaison committee to discuss areas of mutual concern toward the continuation of high quality health care for patients.

Your reference committee recommends that this resolution which would establish a joint liaison committee with the podiatrists be adopted in principle and be referred to the Committee on Relationships with Allied Professions for implementation rather than establish a new or additional committee.

I move the adoption of this portion of the reference committee report.

Your reference committee wishes to commend all the committees submitting reports for the fine work they have done, and personally, I would like to thank the reference committee members and staff for their invaluable assistance.

Report of Reference Committee on Public Service

William G. Ridgway, M.D., chairman, presented the following report of the committee, which was adopted by the House:

Report of the Council on Public Service (Official Reports Book—Pages 101-112)

GENERAL INTRODUCTION

The reference committee commends the Council on Public Service and that part of the staff of the Pennsylvania Medical Society that is concerned with communications for an effective and energetic pursuit of the stated aim: "*To achieve for the physician ideal circumstances consistent with making the highest quality medical care easily available and desirable to all persons.*" The concise yet complete report in the Official Reports Booklet is evidence of searching evaluation of the many vehicles available for communication in 1969 and of decisions aimed at deriving greatest effectiveness from their limited budget. The reference committee feels it worth while to direct attention to the recurring thought stated last year as, "*Effective public relations can best be accomplished by the individual physician in his daily contact with patients and the public in general,*" and this year by the statement of A. Reynolds Crane, M.D.: "*What the medical profession needs is more physicians who love people.*"

The Council comments on suggested trials of providing medical coverage in some rural areas as "satellite screening offices staffed by physician's assistants" and notes the inherent dangers.

Origins, effectiveness evaluations, costs and details of many of the State Society sponsored communications activities are spelled out in the Council report and do not require restating here.

I move the adoption of this portion of the reference committee report.

RADIO AND TELEVISION

Attention is called to "Instant News," "Today's Health," "Today's Health Report." Clarence A. Tinsman, M.D., of the Harrisburg Hospital again rates a "well done" for his work recording the weekly radio programs. His receipt of the "Golden Voice of Medicine" award at the 1969 Officers' Conference is noted with approval. The Council notes the great cost of television time and television show production as a deterrent to greater use of this most effective public communications medium. Cooperation with the Pennsylvania Federation of Women's Clubs in sharing costs and know-how of producing public service TV "spot" announcements is a start in a move authorized last year when this House urged "sharing costs with associations, foundations, and recognized voluntary health agencies." The staff continues to be alert to establishing and maintaining good relations with TV, radio and newscasting personnel. A list of stations visited attests to the effort.

I move the adoption of this portion of the reference committee report.

PRESS AND PUBLICATIONS; SPEAKERS' BUREAU; HEALTH CAREER RECRUITMENT

The committee approves items described under titles: Press Releases, News Media Liaison, Monitor, Service Manual, Health Column, and General Publications.

There is ample evidence of receiving good value from the costs of the Benjamin Rush Awards, the Donaldson Awards, the Fifty-Year Awards and the Centenarian Awards to justify their continuance. The committee joins the council in regretting that many county societies fail to take advantage of some of these programs and suggests to presidents and secretaries of county societies that calling them to the attention of their county society could be worthwhile.

The Speakers' Bureau is a successful and potent public relations improver and should be kept going. Rewarding speakers with certificate or plaque is in order. The course for students, interns and residents on socio-economic aspects of medicine has passed several hurdles and is now well underway on a trial basis. Preceptorships of nine weeks offered by the Appalachian Regional Development Program should be supported. Preceptorships in general have many benefits in addition to the possibility of alerting medical and nursing students to the satisfactions of family practice in non-urban areas. SAMA officers rightly have been included in Society functions and thinking.

The reference committee suggests that the council continue efforts to interest youth in careers in the health fields. A newsletter directed to clubs for health career and Boy Scout Explorer Posts should be worthwhile.

I move the adoption of this portion of the reference committee report.

PENNSYLVANIA ASSOCIATION OF MEDICAL ASSISTANTS; PAMPHLET DISTRIBUTION; COUNTY SOCIETY SECRETARY ORIENTATION; MEMBERSHIP CAMPAIGN; RURAL HEALTH; SPECIAL WRITING PROJECTS; PR AIDS FOR COUNTY SOCIETIES; FILM LIBRARY; AND GENERAL EXHIBITS

Should we state in official proceedings: "We love our medical assistants" we could be quoted out of context. It is, however, proper to remind the Society of the immense devotion of the PAMA to the aims of our organization and to again suggest that members actively support the membership of their office personnel in PAMA. Distribution of pamphlets is in order. The program for orientation of secretaries of county medical societies should be an effective one. Continuing

effort should be made to encourage secretaries to make this visit to the State Society offices.

The Council has directly assumed the functions of the Commission on Rural Health since its abolishment last year. The report notes that five physicians have been aided in locating by the Physician Placement Service and four others have been placed since the report was written. The State Society hosted the AMA's Twenty-Second National Conference on Rural Health in Philadelphia. The Society is alert to writing functions, speeches for officials, summaries of the annual sessions, accomplishments of society programs. The committee approves of continuing distribution of PR aids to county societies, of the film library activities, and of the report of general exhibits.

I move the adoption of this portion of the reference committee report.

RECOGNITION OF PENNSYLVANIA PHYSICIANS' VOLUNTARY SERVICE

The Council recommends and this reference committee moves the adoption of the following tribute to the voluntary services of Pennsylvania physicians:

"Pennsylvania physicians have been in the forefront of those whose compassion has caused them to donate freely of their time, art and science to the service of others. This service without personal financial reward has been given under a variety of governmental, private, religious and individual efforts in many areas of the world, the nation, the state and often in the more familiar surroundings of a physician's own community.

"No full measure can be made of their contributions; that record is kept by God and by the people that they have helped. Their code is one for all physicians to follow, whether it be lived on a Vietnam forest path, a hospital ship, at an African missionary hospital, in a ghetto in our own country or in the instances when any patient anywhere needs unselfish help.

"We salute every such Pennsylvania physician and pray that the examples they have set will be followed by all physicians everywhere in their daily lives."

I move the adoption of the above quoted statement of tribute.

HOUSE, BOARD ACTION IMPLEMENTATION, CONCLUSION

The committee recommends that the invitation to county societies to hold meetings in the State Medical Society building in Lemoyne be held open. Approval of the report on anti-quackery campaign is in order. Items listed under titles: "Educational Help for all Students," TV Program Co-sponsorship, Contacting Non-member Physicians and Anti-Smoking Actions merit approval.

It is evident that the members and staff of the Council on Public Service have done a superb job in the communications field and that they have worked long and hard to make this progress report possible. They merit our thanks.

In the reference committee discussions concerning virtually all of the Council's activities, it was apparent that there is only limited implementation on the county society level because of the unavailability of staff. To provide desirable services to both physicians and the public, the reference committee feels that it is wise to have staff services universally available. At the same time, it recognizes the many barriers. The committee endorses a recommendation made to the Board of Trustees and Councilors by the Council on Public Service which called for each councilor to evaluate the need for staff services in his district.

I move the adoption of this portion of the reference committee report.

Recommendation "A," Health Conference (Address of the President, and Appendix "A" to the President's Address published in the November, 1969, PENNSYLVANIA MEDICINE)

The committee commends Dr. Farrar for his calling to the attention of the society the void in leadership of coordinating all elements of health services in the state. Being fully aware of our budget limitations, the committee recommends consideration of his suggestion of sponsoring a Governor's Health Conference, subject to the availability of funds. Any State Society financial support should be dependent upon the availability of funds.

I move the adoption of this portion of the reference committee report.

Resolution 69:39: Shortage of Practicing Physicians in Western Pennsylvania

WHEREAS, There is a continuing and increasing shortage of practicing physicians in western Pennsylvania, particularly in the smaller communities; and

WHEREAS, It is noted that the 1955 graduating class from the University of Pittsburgh was a total of 91 students and the 1968 graduating class at the same institution was 82, it is apparent that the single medical school in the area is failing to produce a sufficient number of physicians for the needs; and

WHEREAS, Recently the University of Pittsburgh School of Medicine has shortened the teaching of basic science courses to a semester in most cases; therefore be it

Resolved, That the Pennsylvania Medical Society request the Board of Regents of the State Board of Education to discuss with the concerned authorities at the University of Pittsburgh School of Medicine, the possibility of starting two medical classes per year. This would have the dual effect of doubling the number of graduates and doubling the utilization of the expensive teaching facilities at the University of Pittsburgh; and be it further

Resolved, That the feasibility of using all, or nearly all, of the hospitals in the Pittsburgh area be discussed, since this would increase the amount of clinical instruction available to the students. It is envisioned that the University of Pittsburgh School of Medicine would clearly define its objectives as the production of practicing physicians for the area in which it is located and have as a secondary objective the producing of research papers.

The reference committee appreciates the intent of Resolution 69-39 and recognizes the extreme need to increase the number of practicing physicians. However, the resolution as introduced is specific in its criticism and regionalized in its intent whereas any valid criticism of a particular medical school probably would apply equally to all medical schools and the shortage of practicing physicians is not limited to a specific part of the state. We feel that all medical schools are aware of the need to produce more practicing physicians. We hope that the Pennsylvania Medical Society will prod medical schools toward this goal where

prodding will help and that it will support the goals of medical schools where such support is warranted and in the best interests of the public and the profession. The problem with which the resolution is concerned is one of the more complex ones facing the profession and your reference committee is unable to arrive at what it feels would be a specific solution. Therefore, your reference committee recommends that Resolution 69-39 be referred to the Board of Trustees and Councilors for the information of the appropriate Society body.

I move the adoption of this portion of the reference committee report.

Report of Reference Committee on Miscellaneous Business

Katherine R. Sturgis, M.D., chairman, reported that no business was referred to the Committee on Miscellaneous Business at the 1969 Session.

Report of Reference Committee on Reports of Officers

Robert J. Carroll, M.D., chairman, presented the report of the committee which was amended by the House and adopted as follows:

Report of the Board of Trustees and Councilors (Official Reports Booklet, Page 19)

The Board of Trustees recommends that the meeting of the 1974 House of Delegates be held in Pittsburgh. Your reference committee concurs with this recommendation.

I move the adoption of this portion of the reference committee report.

The rest of the report of the Board is largely informational. Your reference committee commends the Board of Trustees for making adequate disposition of all the resolutions referred to it by the 1968 House of Delegates.

I move the adoption of this portion of the reference committee report.

Report of the Secretary (Official Reports Booklet, page 27)

The reference committee carefully studied the PMS Judicial Council's analysis of Resolution 68-13, "Fee for Service."

The "Resolved" clause as adopted states:

> *"Resolved,* That the Pennsylvania Medical Society declare it to be unethical for a physician to submit or to collect a fee for medical, obstetrical, or surgical service unless the physician is personally present when the service is rendered."

The Judicial Council recommends that the "Resolved" portion of Resolution 68-13 should be amended as follows:

> *"Resolved,* That the Pennsylvania Medical Society declare it to be unethical for a physician to submit or to collect a fee for medical, obstetrical, or surgical service unless the physician personally provides or personally supervises the service rendered."

The bulk of testimony before the committee favored the retention of the resolution as originally adopted.

Your reference committee recommends that the Judicial Council revision of the Resolution 68-13 be not approved and that the action of the 1968 House of Delegates be reaffirmed.

The House did not agree with its reference committee, it rejected the recommendation of the reference committee and adopted the recommendation of the Judicial Council that Resolution 68-13 be amended as proposed above.

The reference committee has reviewed the implementation of Resolution 68-25, "Discrimination," which called for the Society to request the AMA to clarify the term "repeated violations" as it applies to medical associations which manifest prejudice against minority groups. Your reference committee concurs with the opinion of the PMS Judicial Council that the Judicial Council of the AMA should be permitted to exercise discretion in formulating its judgments and implementing the intent of the AMA House of Delegates. The reference committee believes that no further action on the part of the State Society is necessary at this time.

I move the adoption of this portion of the reference committee report.

The reference committee notes that Allen W. Cowley, M.D. concludes his term as Secretary at this meeting of the House of Delegates. The committee recommends that the House of Delegates commend and thank Dr. Cowley for his seven years of service as Secretary.

I move the adoption of this portion of the reference committee report.

Report of the Executive Director (Official Reports Booklet, page 29)

The reference committee read with deep interest the report of the Executive Director. It represents the last report that Mr. Lester H. Perry will make as Executive Director. Your reference committee recommends that the House of Delegates express its deep appreciation for Mr. Perry's long and dedicated years of service.

I move the adoption of this portion of the reference committee report.

Report of the Treasurer (Official Reports Booklet, page 33)

Your reference committee has reviewed the report of the Treasurer. We joyfully note the presence of a surplus.

I move the adoption of this portion of the reference committee report.

Report of the Accountant (Official Reports Booklet, page 33)

The reference committee has reviewed the report of the Society's certified public accountants, and is pleased to note that no adverse comments were made.

I move the adoption of this portion of the reference committee report.

Reports of the Individual Trustees and Councilors (Official Reports Booklet, pages 38-62)

The reports of the Trustees are informational with the exception of a recommendation contained in the report of the Tenth Councilor District. Referring to Lawrence County, Dr. Kelly recommends that "The Pennsylvania Medical Society explore the means of providing at least a part-time executive secretary for this society, so that this society can get back into the main stream of organized medical activity."

Your reference committee recommends that this matter be referred to the Board of Trustees with the recommendation that the reference committee would prefer that there be no direct financial aid for the county society.

The other reports of the individual councilors do not contain any items requiring action.

I move the adoption of this portion of the reference committee report.

Resolution 69-1—Medical Staff Rights (Official Reports Booklet, page 124)

> WHEREAS, There is evidence of a growing trend by hospital boards of directors to change the traditional relationships which have existed between the medical staff and these

Let's be specific about Campbell's Soups... and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

in acute and chronic diarrheas

LOMOTIL® SAVES...

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contain:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate. 0.025 mg. (1/2,400 grain)

body fluids...
electrolytes...
patients from exhaustion

Lomotil acts promptly and directly to lower the excessive intestinal motility of diarrhea. This therapeutic restraint on the overactive bowel allows a normal or more nearly normal reabsorption of water and electrolytes.

The proficiency of Lomotil in conserving body fluids and electrolytes often saves patients from the exhaustion that accompanies prolonged diarrhea.

Lomotil acts to control the intestinal mechanisms of diarrhea; therefore, it is highly useful in controlling diarrhea associated with:

gastroenteritis · acute infections · functional hypermotility
irritable bowel · ileostomy · drug-induced diarrhea

Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:	*Total Daily Dosage*
3-6 mo.	½ tsp.* t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

G. D. SEARLE & CO.
Research in the Service of Me
951

this ulcer did not heal...until its surface was cleared of dead tissue and debris

FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.

to aid in debridement to facilitate healing in chronic cutaneous ulcers...

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(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

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governing boards; and

WHEREAS, The Judicial Council of the Pennsylvania Medical Society has determined that the removal from the medical staff of the responsibility to recommend appointments and reappointments to the medical staff is in violation of Section 6 of the Principles of Medical Ethics; and

WHEREAS, The Judicial Council of the Pennsylvania Medical Society has stated that the medical staff is the sole determining body for the content of its by-laws and that any procedure instituted by a body other than the medical staff, requiring revision of these by-laws, would be a violation of the Principles of Medical Ethics; therefore be it

Resolved, That the Pennsylvania Medical Society should instruct its delegates to the AMA House of Delegates to introduce a resolution containing updated guidelines covering the relationships between boards of directors of hospitals and their respective medical staffs which relationships have been delineated by the Judicial Council of the Pennsylvania Medical Society; and be it further

Resolved, That this resolution should call upon the American Medical Association to include these guidelines under the purview of Section 6 of the Principles of Medical Ethics.

Your reference committee has considered and concurs with Resolution 69-1. I move the adoption of Resolution 69-1.

Resolution 69-2—Hospital Staff Privileges (Official Reports Booklet, page 125)

WHEREAS, Every patient has the right to his choice of physician; and

WHEREAS, The establishment of full-time, salaried department heads is becoming increasingly popular among hospitals in Pennsylvania; and

WHEREAS, The Pennsylvania Medical Society has a long history of supporting the free practice of medicine; therefore be it

Resolved, That every physician should be assured a hospital appointment and every physician, salaried or in private practice, be given privileges consistent with his abilities as judged by the broad base of his peers, the members of the hospital staff.

Your reference committee concurs with the general intent of this resolution. However, we do not support the categorical statement that ". . . every physician should be assured a hospital appointment . . ." Hospital appointments and the extent of privileges should be determined by the medical staff of the hospital involved. Your reference committee recommends that the "Resolved" portion of the resolution be amended by deletion of the phrase ". . . every physician should be assured a hospital appointment and . . ." so that the "Resolved" clause reads as follows:

Resolved, That every physician, salaried or in private practice, be given privileges consistent with his abilities as judged by the broad base of his peers, the members of the hospital staff.

I move the adoption of the amendment to Resolution 69-2.

I move the adoption of Resolution 69-2 as amended.

Resolution 69-9—Study and Evaluation of the Educational and Scientific Trust's Projects (Official Reports Booklet, page 126)

WHEREAS, The voluntary contribution of physicians to scholarship funds has proved to be a worthwhile and effective program in enabling students to pursue the study of medicine; and

WHEREAS, The number of governmental programs has steadily diminished the need for this type of scholarship help; and

WHEREAS, We believe that a re-evaluation of such scholarship programs is necessary; and

WHEREAS, Problems in other areas have been equally as important; therefore be it

Resolved, That the Pennsylvania Medical Society conduct a study and evaluation of the use of the funds presently in the Educational and Scientific Trust to determine the feasibility of utilizing a portion of these funds to provide, on a loan basis, funds to general practitioners which would enable them to establish practices in the rural areas of Pennsylvania.

Your reference committee has considered this resolution carefully and is doubtful that a loan program to provide funds to general practitioners who want to establish practice in rural areas of the State will have the desired effect of attracting more generalists to outlying areas. However, your reference committee does not oppose the concept of studying the possibility of such a program as called for in the resolution.

Your reference committee would like to point out that the second "Whereas" of this resolution is no longer accurate since at the present time the student loan money from the Federal Government is drying up.

I move the amendment of Resolution 69-9 by deletion of the second "Whereas" clause.

I move the adoption of Resolution 69-9 as amended.

Resolution 69-15—Representation of Specialty Societies in the House of Delegates (Official Reports Booklet, page 128); *Resolution 69-27—Specialty Societies in House of Delegates* (Official Reports Booklet, page 131); *Resolution 69-25—Interspecialty Committee* (Official Reports Booklet, page 130); *President's Address—(F) Splintering; Supplemental Report C, Board of Trustees* (Official Reports Booklet, page 135)

RESOLUTION 69-15

WHEREAS, Over 6,000 of the 12,000 members of the Pennsylvania Medical Society are certified specialists; and

WHEREAS, Specialists are playing an increasingly prominent role in hospital functions; and

WHEREAS, It becomes increasingly important that all segments of the medical spectrum of Pennsylvania should participate in the Pennsylvania Medical Society; and

WHEREAS, Presentation of the point of view of the specialists in the House of Delegates is presently incomplete and representation of specialists in the House of Delegates has been recognized by the American Medical Association for many years; therefore be it

Resolved, That the established medical specialty societies in Pennsylvania representing anesthesia, chest physicians, dermatology, gen-

eralists, general surgery, internal medicine, obstetrics and gynecology, neurosurgery, orthopedics, pathology, pediatricians, physiatrics, psychiatrists, thoracic surgery, and urology, and other recognized specialty societies be invited to send a voting delegate to the House of Delegates of the Pennsylvania Medical Society for a trial period of two years.

RESOLUTION 69-27

WHEREAS, It has long been recognized that there is need for more effective cooperation between specialist groups and the Pennsylvania Medical Society; and

WHEREAS, The House of Delegates of the American Medical Association at its meeting in July, 1969 acted at the national level to provide one delegate and one alternate delegate for each of twenty-two specialty groups, with the proviso that such delegates and alternate delegates be active members of the American Medical Association; and

WHEREAS, The House of Delegates of the American Medical Association, in its program of implementation of such representation, avails itself of contact with national specialty organizations listed in the American Medical Directory; and

WHEREAS, There are at this time in Pennsylvania twelve specialty organizations that have ninety or more American Board-certified Pennsylvania physicians of each such specialty group who are also active members in the American Medical Association (namely anesthesiology, dermatology, internal medicine, neurology, psychiatry, obstetrics and gynecology, ophthalmology, orthopedics, otolaryngology, pathology, pediatrics, surgery, and urology); therefore be it

Resolved, That the By-laws of the Pennsylvania Medical Society be amended to permit the addition to its House of Delegates of one delegate and one alternate delegate for each specialty group with ninety or more American Board-certified physicians in Pennsylvania who are also American Medical Association active members; and be it further

Resolved, That the selection of such delegates and alternate delegates to serve in the manner and for the terms customary for delegates and alternate delegates for the above-mentioned specialties be made by the Board of Trustees and Councilors from lists, each of which contain the names of three eligible (i.e., American Board-certified and with American Medical Association active membership) Pennsylvania physicians for each delegate, and for each alternate delegate; said lists to be furnished by the appropriate specialist organization (recognition in the American Medical Directory).

RESOLUTION NO. 69-25

WHEREAS, It is desirable that medical organizations work in harmony; and

WHEREAS, The Medical Society of the State of Pennsylvania is the only organization that represents all Pennsylvania physicians and is, therefore, the best qualified to speak for the medical profession; and

WHEREAS, Formal liaison between specialty organizations in Pennsylvania and the Pennsylvania State Medical Society would be an effective instrument in qualifying the Pennsylvania State Medical Society to be the official voice of organized medicine in Pennsylvania; now therefore be it

Resolved, That the House of Delegates of the Pennsylvania Medical Society encourage the establishment of a committee of physicians officially representing all specialty organizations in the State of Pennsylvania, such physician-members to be nominated by their respective specialty societies and appointed by the President of the Pennsylvania Medical Society; and be it further

Resolved, That this committee be known as the Interspecialty Committee charged with the responsibility of reviewing policy, socio-economic matters, legislation, and other subjects affecting specialty practices, and the relationship between specialty organizations and the Pennsylvania Medical Society; and be it further

Resolved, That this committee report periodically to the House of Delegates.

Your reference committee has considered several resolutions, Supplemental Report C of the Board of Trustees and the portion of the President's Address relating to the problem of specialty representation in the State Society. We recognize the great need for increased communication on a regular basis between the State Society and the specialty societies. Two mechanisms are proposed: (1) Certification of delegates from specialty societies, and (2) The formation of an interspecialty committee. There are cogent reasons why the interspecialty committee approach is preferred.

The bulk of testimony before the committee favored the interspecialty committee approach. At the AMA both methods have been used. The interspecialty committee method has been found to be more effective.

The Board of Trustees has already approved the establishment of an Interspecialty Committee at its meeting on Wednesday, October 8. We urge the adoption of Resolution 69-25 and the portion of Dr. Farrar's address on this subject and recommend that they be referred to the Board of Trustees and Councilors for implementation.

I move the adoption of Resolution 69-25 and the portion of the President's Address dealing with the formation of an interspecialty committee.

Your reference committee recommends the rejection of Resolution 69-15 and Resolution 69-27.

Resolution 69-28—Implementation of House Actions (Official Reports Booklet, page 131)

WHEREAS, Many resolutions are passed by the House of Delegates of the Pennsylvania Medical Society at its annual sessions; and

WHEREAS, There is need for the delegates to be kept informed on the implementation of such resolutions; therefore be it

Resolved, That the Pennsylvania Medical Society establish a committee with the following functions:

1. To make certain that, after referral of resolutions to the appropriate committees and Councils of the Pennsylvania Medical Society by the House of Delegates, that the results of the reference committees' study has been reported back to the House; and
2. To keep informed as to the status of implementations of resolutions by the House of Delegates.

Your reference committee believes that the creation of a committee to do

what is essentially an administrative task would be a duplication of effort. The Board of Trustees and the executive director already assure the implementation of approved resolutions. The result of this implementation is contained in the annual reports to the House of Delegates. Each year in its report the Board of Trustees publishes a brief summary of the resolutions considered the previous year and directs the reader to the appropriate report which contains detailed information concerning implementation.

At the reference committee hearing Dr. Limberger pointed out that the Board of Trustees will be happy to provide county medical societies with periodic reports concerning the implementation of adopted resolutions.

As a consequence your reference committee believes that the committee called for in this resolution is not necessary.

I move that Resolution 69-28 be not adopted.

Supplemental Report "A" of Board of Trustees (Official Reports Booklet, page 133)

Your reference committee shares with the Board of Trustees the conviction that the problems created by the development and use of computer technology with reference to privileged communications is a problem of national scope. The reference committee concurs with the Board of Trustees that the "Resolve" portion of Resolution 68-17 should be amended as follows:

> *"Resolved,* That the Pennsylvania Medical Society seek the results of the studies being conducted by the American Medical Association on computer technology, with particular reference to privileged communications and the use of medical data stored by non-medical agencies; and be it further
>
> *"Resolved,* That these materials be considered by the appropriate council or committee with a view toward recommending appropriate action to the Board of Trustees and House of Delegates."

I move the adoption of the amended "Resolve" portion of Resolution 68-17.

I move the adoption of Resolution 68-17 as amended.

Supplemental Report "B" of Board of Trustees (Official Reports Booklet, page 134)

Your reference committee has carefully reviewed the contents of this report, which is submitted to the House as information.

I move the adoption of this portion of the reference committee report.

Report of Pennsylvania Delegation to the AMA; Also Its Supplemental Report (Official Reports Booklet, pages 123 and 136 respectively)

Dr. Wendell B. Gordon appeared before the reference committee to request that the report of the Committee to Nominate Delegates and Alternates to the AMA be corrected. He wished to make it clear that he did not voluntarily retire as a member of the Delegation.

The reference committee wishes to express its delight and pride in the fact that four Pennsylvania physicians were elected to high offices by the AMA House of Delegates. We were gratified to learn that the AMA House acknowledged the contribution to the medical profession which Mr. Lester H. Perry, our executive director, has made during his years of service.

I move the adoption of this portion of the reference committee report.

Report of the Committee on Objectives (Official Reports Booklet, page 69)

The reference committee concurs with the recommendation concerning the development of a model plan for councilor district reorganization.

I move the adoption of the recommendation relating to Councilor District Reorganization and that the Committee on Objectives be charged with the development of a model plan.

Report of the Committee on Aid to Education (Official Reports Booklet, page 62); *Supplemental Report of the Committee on Aid to Education* (Copies available from PMS Headquarters)

Your Reference Committee has reviewed these reports, which are informational.

I move the adoption of this portion of the reference committee report.

Report of the Educational and Scientific Trust (Copies available from PMS Headquarters)

Your reference committee has reviewed this report, which is informational.

I move the adoption of this portion of the reference committee report.

President's Address (G) Term Limit For AMA Delegates (Published in November, 1969, PENNSYLVANIA MEDICINE)

Your reference committee considered the recommendation at length. The preponderance of testimony did not favor adoption of this recommendation in its present form. As was pointed out when this was considered by the House in 1968, some physicians who have distinguished records of leadership at the AMA level could never have achieved high office in the AMA if they had been removed from the Delegation at a mid-point in their service.

Your reference committee recommends that this be referred to the Committee on Objectives for study and recommendation to the 1970 House of Delegates.

President's Address (H) Popular Election of Officers of Pennsylvania Medical Society (Published in November, 1969, PENNSYLVANIA MEDICINE)

Your reference committee feels that this suggestion has merit but does not feel that there is enough information available at this time for it to be considered by this House of Delegates.

I move that this portion of the President's Address be referred to the Committee on Objectives for study and recommendation to the 1970 House of Delegates.

President's Address (K) Advisory Committee On Health Care (Published in November, 1969, PENNSYLVANIA MEDICINE)

Your reference committee recommends reaffirmation of the action taken by the House in 1968 and that this committee be created on a trial basis.

I move the adoption of this portion of the report of the reference committee.

President-Elect's Address (Published beginning p. 105, this issue of PENNSYLVANIA MEDICINE)

The remarks of Dr. Barrett required no specific action on the part of the reference committee although the objectives he outlined will merit careful attention in the months ahead by the various administrative units of the Society.

I move the adoption of this portion

of the reference committee's report.

Remarks of Robert Slama, President SAMA Chapter, Temple University School of Medicine

The Speaker recognized Robert Slama, president of the SAMA Chapter of the Temple University School of Medicine, to apprise the House of the planned activities of medical students in connection with the Vietnam War Moratorium of October 15, 1969.

Report of Reference Committee on Governmental Relations

William C. Ryan, M.D., chairman, presented the following report of the committee which was adopted by the House:

Report of the Council on Governmental Relations (Official Reports Booklet, Pages 78-81)

The reference committee has reviewed the Report of the Council on Governmental Relations, which reports on the charges made to it by the 1968 Session of the House of Delegates. The Council reports on actions it has taken on Resolutions referred to it concerning "Usual and Customary Fees for Commonwealth Programs"; "Medical Representation on State Advisory Committees for Allocation of Hill-Harris Funds"; "Priority for Adequately Financing the Medicaid Program"; "Animals for Research and Teaching"; "International System of Highway Signs"; "Representation of Medical Schools on State Board of Medical Education and Licensure"; "Unscientific Practices and Practitioners in Pennsycare"; as well as activities in the field of "Informed Consent" legislation; "Medical Examiner" system and "Uniform Anatomical Gifts." Your reference committee was interested in learning of the drafting and submission of a bill to place a dean of a medical school or his representative on the State Board of Medical Education and Licensure. Your reference committee cannot help but be impressed with the wide latitude of legislative and governmental administrative problems which this Council faces year to year.

At the very beginning of the Council's Report, the note is made that 1969 is the first year of a two-year session for both the General Assembly of the Commonwealth and the Congress of the United States so that very little final action can be expected or reported on the many issues in which the Council has an interest. The House of Delegates should look forward to a final report on these vital issues at the 1970 Session. However, this House should go on record as supporting the activities of the Council on Governmental Relations and encourage them to pursue their interests and the interests of organized medicine in Pennsylvania with continuing vigor.

I move the adoption of this portion of the reference committee report.

Supplemental Report of the Council on Governmental Relations (Available from PMS Headquarters)

The Supplemental Report of the Council is very interesting. The reading of it is certainly an easy way for bringing all members up to date on the legislation in which medicine has an interest. Here again, a review of this chart demonstrates the many and varied legislative activities which are being undertaken by the Council. The Council is to be complimented for its activities, but the reference committee feels that our legislative information and contact program is still not near its optimum. The 1968 reference committee suggested that the Council look into this matter with a view to remedying it. Testimony taken at the hearing indicates that much information is being disseminated to county societies, but comparatively little action seems to ensue. Other testimony presented by representatives of the Council and the Pennsylvania Medical Political Action Committee indicate that they are continuing their work on a "contact doctor" system, designed to make available to each legislator the advice of a physician, and that the major efforts are being conducted in selected areas of the State where a majority of the Representatives from these areas are represented on committees in the House and Senate with which medicine must work. The efforts thus far have been productive but your committee feels that they are not as productive as they might be if all physicians who have personal friends in the Legislature cooperate. Accordingly your reference committee commends the Council on its activities following the 1968 Session of the House of Delegates, and urges it to redouble its efforts in this regard and also encourages county medical societies to cooperate in the effort when they are called upon by the Council and the Pennsylvania Medical Political Action Committee for this vital information.

I move the adoption of this portion of the reference committee report.

Address of Carl B. Lechner, M.D. (Published in November, 1969, PENNSYLVANIA MEDICINE)

The referral of Dr. Lechner's prepared statement to this committee was very worthwhile, for, in addition to its reflections by a man who is extremely well versed in medical affairs, it gives some answers to us which we need in this area of governmental relations. I would like to quote several pertinent paragraphs from this excellent paper:

> "I propose to stir up greatly enhanced political activity at the county level, supervised and stimulated by the State Society. I advise a campaign to get every doctor, every auxiliary member, every dependent and every assistant to learn about partisan politics. I propose that we urge and assist county societies to entertain at separate times the chairmen of political parties of their choice. The auxiliary can be depended upon to spread this activity widely.
>
> "We should remember that in education and political action our arm is PaMPAC. Methods of increasing its financial support are essential. More publicity could be obtained if the society were to make more space available in PENNSYLVANIA MEDICINE. The concerted action of this movement is essential to us.
>
> "We need a similar step-up in our legislative program. I propose that the State Society ask each county society to restructure its legislative committee so that each committeeman will have an assigned group of members. With the help of the auxiliary and of PAMA it might be possible to do a much better job than we have done in reaching our members when an important legislative decision is imminent. In addition, we should mount a campaign to inform every member of the identity of his legislators and how to communicate with them.
>
> "We should implement the system by which each county society forms a committee of physicians and auxili-

ary members to act as an advisory group on medical affairs. This should be done for any legislator, state or national, who resides in that county.

"I also propose that we establish more 'political and legislative friends'. We have already been joined in such activity by the Pennsylvania Osteopathic Association. In addition we should secure cooperation from the Dental Society, nursing organizations at all levels, with pharmacists and with organizations of paramedical professionals."

We recommend that these remarks be forwarded to the Council on Governmental Relations.

Resolution 69-17: Air Pollution Control (Official Reports Booklet, Page 128)

WHEREAS, The membership of the Pennsylvania Medical Society is deeply concerned with the well-being of Pennsylvania citizens; and

WHEREAS, Pollution of the ambient air is a threat to the health of our people, especially to those who suffer from cardiorespiratory disease; therefore be it

Resolved, That the Pennsylvania Medical Society urge the Pennsylvania legislature to initiate and support sound measures to reduce current air pollution, at least to such levels as are and will be set forth as criteria by the federal government; and be it further

Resolved, That the Air Pollution Control Committee of the Pennsylvania Medical Society keep our membership informed as to goals pending in the field of air pollution control in order that our members may send letters of strong support for such legislation to appropriate members of the state legislature, including committee chairmen and members.

Your reference committee has reviewed Resolution 69-17 and observes that there never seems to be enough legislation "on the books" to take care of this very vital public health problem. Your committee, in considering this resolution, took into account the report from the Commission on Environmental Health of the Council on Education and Science which suggests support of Senate Bill No. 278. This measure would add a physician to the State's Air Pollution Control Commission, which would seem to be a partial answer to getting medicine's views into the air control activity at State level. The State Society has been one of the leaders in the fight to gain more adequate air pollution control legislation and should continue to do so. Consequently, your reference committee recommends that Resolution 69-17 be amended so that in the final RESOLVE, the words "Air Pollution Control Committee" be changed to read the *Commission on Environmental Health.*

I move the adoption of Resolution 69-17 as amended.

Resolution 69-18: Therapeutic Abortion Legislation (Official Reports Booklet, Page 128)

WHEREAS, The danger to maternal health is substantial from abortions performed illegally; and

WHEREAS, The magnitude of illegal abortions is considerable; therefore be it

Resolved, That the Pennsylvania Medical Society seek introduction and passage of legislation in the state legislature to the following points:

1. Licensed therapeutic abortions shall be permissible if it can be reasonably established that (a) there is risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother, or (b) there is substantial risk that the child will be born with grave physical or mental defect, or (c) the pregnancy resulted from statutory or forcible rape or incest;
2. Therapeutic abortions must be approved by a committee of not less than three licensed physicians;
3. Therapeutic abortions shall be performed only in accredited hospitals; and be it further

Resolved, That copies of this resolution be sent to the governor, majority and minority leaders of the Senate and the House of the Pennsylvania General Assembly, as well as to the chairmen and members of appropriate committees of the Pennsylvania General Assembly.

Mr. Speaker, the reference committee, in discussing Resolution 69-18, was made aware of the long-standing position of this House's favoring such legislation. Your reference committee was extremely pleased to have representation from the Student American Medical Association and the benefit of their organization's thinking. They were most helpful. It was in 1967 that the Society took action favoring legislation for therapeutic abortions under the circumstances enunciated in this resolution. The previous position is a much broader statement whereas this resolution is restrictive.

I move that Resolution 69-18 not be adopted.

I move that this House reaffirm our action of 1967 when it adopted Supplemental Report A of the then Council on Scientific Advancement.

Resolution 69-33: Medico-Legal Protection for Ambulance Attendants

WHEREAS, Ambulance service is an important and integral part of medical care; and

WHEREAS, Ambulance service emergency care extends beyond the usual scope of paramedical training; and

WHEREAS, Danger of medico-legal repercussions presents a problem; therefore be it

Resolved, That the Pennsylvania Medical Society prepare legislation, for introduction into the Pennsylvania General Assembly, that will protect these ambulance attendants while performing their duty.

The reference committee has considered Resolution 69-33, which calls for protection from liability for ambulance attendants similar to that extended to physicians in the so-called "Good Samaritan" legislation.

Your committee has learned that there is already legislation on the books to exempt firemen, policemen and members of volunteer ambulance and rescue squads when they are in the performance of their duties. The amendment to include these persons was added to the "Good Samaritan Law" by the State Legislature in 1967. For this reason, I move that Resolution 69-33 not be adopted.

Resolutions 69-34 and 69-37: Separate Department of Mental Health/Mental Retardation

RESOLUTION 69-34

WHEREAS, Since the passage and initial implementation of the Comprehensive Mental Health/Men-

tal Retardation Act of 1966 has resulted in a great expansion of mental health activities in Pennsylvania, there is an urgent need to place the unique problems of implementation in the forefront of the activities of the Commonwealth, which can best be accomplished by the establishment of a separate Department of Mental Health within the executive branch of the state government, where it will receive proper recognition, direction and emphasis; and

WHEREAS, Based upon experience there is a marked nation-wide trend toward independent departments of mental health, especially among the major industrial states, with only twelve states still retaining mental health within public health departments; and

WHEREAS, The present Department of Health has been oriented almost exclusively to public health concerns and mental health programs have a different orientation; and

WHEREAS, The size and complexity of the Mental Health/Mental Retardation Program, with nearly one-third of all Commonwealth government employees, demands that it not be submerged in any department; and

WHEREAS, An administrative attempt was made during the past year, which embodied the aims of the substitute resolution for Resolution 66-12 and encountered massive opposition from those organizations concerned with Mental Health/Mental Retardation; therefore be it

Resolved, That the substitute resolution, which replaced Resolution 66-12, stating that the Pennsylvania Medical Society take proper steps to encourage the transfer of the Office of Mental Health from the aegis of the Department of Welfare to that of the Department of Health be rescinded; and be it further

Resolved, That the Pennsylvania Medical Society recommend to the appropriate persons or agencies in state government that a separate Department of Mental Health be established under the direction of a qualified psychiatrist; and be it further

Resolved, That an acceptable alternative to a separate Department of Mental Health would be the umbrella department concept of human services with separate and equal offices for health, welfare, and mental health.

RESOLUTION No. 69-37

WHEREAS, The passage and initial implementation of the Comprehensive Mental Health/Mental Retardation Act of 1966 has resulted in a great expansion of mental health activities in Pennsylvania, there is an urgent need to place the unique problems of implementation in the forefront of the activities of the Commonwealth, which can best be accomplished by the establishment of a separate Department of Mental Health within the executive branch of the state government, where it will receive proper recognition, direction and emphasis; and

WHEREAS, Based upon experience there is a marked nation-wide trend toward independent departments of mental health, especially among the major industrial states, with only twelve states still retaining mental health within public health departments; and

WHEREAS, The present Department of Health has been oriented almost exclusively to public health concerns and mental health programs have a different orientation; and

WHEREAS, The size and complexity of the Mental Health/Mental Retardation program, with nearly one-third of all Commonwealth government employees, demands that it not be submerged in any department; and

WHEREAS, An administrative attempt was made during the past year, which embodied the aims of the substitute resolution for Resolution 66-12 and encountered massive opposition from those organizations concerned with Mental Health/Mental Retardation; therefore be it

Resolved, That the substitute resolution, which replaced Resolution 66-12, stating that the Pennsylvania Medical Society take proper steps to encourage the transfer of the Office of Mental Health from the aegis of the Department of Welfare to that of the Department of Health be rescinded; and be it further

Resolved, That the Pennsylvania Medical Society recommend to the appropriate persons or agencies in state government that a separate Department of Mental Health be established under the direction of a qualified psychiatrist.

Your reference committee heard a great deal of testimony on these resolutions from a variety of individuals and organizations. Prior to our open hearing, we had invited representatives of Penn-Mental Health Association, the Pennsylvania Psychiatric Society and The Community Services of Pennsylvania, and all were represented. The committee also reviewed the action taken by this House at its 1966 Session, when it rejected a similar resolution. In addition to the information gleaned at the open hearing, our executive session considered it at greater length than any other of our assigned subjects. Your committee recommends the following substitute Resolution 69-34:

WHEREAS, Since the passage and initial implementation of the Comprehensive Mental Health/Mental Retardation Act of 1966 has resulted in a great expansion of mental health activities in Pennsylvania, there is an urgent need to place the unique problems of implementation in the forefront of the activities of the Commonwealth; and

WHEREAS, Studies by the Pennsylvania Mental Health Association show a marked nation-wide trend toward independent departments of mental health and retardation, especially among the major industrial states, with only twelve states still retaining mental health within public health departments; and

WHEREAS, The present Department of Health is oriented almost exclusively to public health concerns and mental health programs have a different orientation; and

WHEREAS, The size and complexity of the Mental Health/Mental Retardation program, with nearly one-third of all Commonwealth government employees indicates that it not be submerged in any other department; and

WHEREAS, An administrative attempt was made during the past year to place Mental Health/Mental Retardation services within the Department of Health and encountered massive opposition from some organizations concerned with Mental

Health/Mental Retardation; therefore be it

Resolved, That the Pennsylvania Medical Society recommend to the appropriate persons or agencies in state government that a separate Department of Mental Health/Mental Retardation, established under the direction of a qualified psychiatrist, would best serve the needs of this program; and be it further

Resolved, That an acceptable alternative to a separate Department of Mental Health/Mental Retardation would be an umbrella department concept of Human Services with separate and equal offices for Health, Welfare and Mental Health; and be it further

Resolved, That the Council on Governmental Relations undertake action to insure that whatever governmental administrative arrangement is made, the State's mental health and mental retardation programs obtain the freedom they require within the political system.

I move the adoption of substitute resolution No. 69-34.

Remarks of John L. Kelly, M.D.
Delaware County

The Speaker recognized Delegate John L. Kelly, M.D., of Delaware County, who made the following statement:

"I move that this House take note of the brave patriotic service to our country by those in the Armed Services and express its appreciation by a rising vote of 'thanks' to them."

The statement received a standing vote.

Report of Reference Committee on Medical Service

Harry V. Armitage, M.D., chairman, presented the following report of the committee, which was adopted by the House as amended:

Report of the Council on Medical Service (Official Reports Booklet, Page 81-101)

Resolution 68-1: Usual and Customary Fees for Commonwealth Program

It appears that the Council has made an effort to implement this Resolution but there is no indication that any progress has been made. The reference committee urges the Council to be more rigorous in pursuing this objective since there appears to be a developing sentiment among legislators to embrace fixed fee schedules for payment of physicians' services.

Resolution 68-3: Physicians To Serve on Committees Guiding Programs Created by Public Law 89-749 and Public Law 89-239

The Council has pursued these objectives as vigorously as possible within the restrictions imposed by the federal guidelines which define the composition of the boards. However, the Council's report is not specific and the reference committee suggests that the Council submit a report in tabulated form reflecting the number of physicians participating in these programs.

Resolutions 68-5; 68-28; 68-29: Provision of an Adequate Concurrent and Consecutive Care Program by Pennsylvania Blue Shield

The Council officially notified Blue Shield of the adoption of these resolutions but, as of this date, no action has been taken. The reference committee suggests that this matter be referred again to the Council on Medical Service to determine the stage of implementation of Resolutions 68-5, 68-28, and 68-29.

Resolution 68-12: Availability of Medical Care and President's Address—Section C—Slums (Published in November, 1969, PENNSYLVANIA MEDICINE)

This resolution has not been implemented. The Council has been frustrated in its attempts to formulate a plan which would assure the availability of high quality medical care to all segments of the population in Pennsylvania. However, the Council has suggested methods of assuring improved financing with the feeling that better reimbursement will improve the availability of medical care.

The Supplemental Report of the Council on Medical Service dated September 14, 1969, was accepted as a reasonable implementation in principle of Resolution 68-12. (The Supplemental Report of the Council is Appendix D, page 111.)

Furthermore, your reference committee suggests that the President's recommendation concerning provision of comprehensive medical care in urban and rural slums be referred to the Council on Medical Service for further consideration.

I move the adoption of this portion of the reference committee report.

Resolution 68-15: Blue Shield Prevailing Fee Program

This resolution is being effectively implemented.

Pennsylvania Blue Shield; Pennsylvania Blue Shield Report to House of Delegates (Available from PMS Headquarters)

The Council has been diligent in carrying out its liaison responsibilities with Blue Shield and is to be commended.

Your reference committee has carefully perused the Report to the House of Delegates from Pennsylvania Blue Shield and is pleased to learn of the continued growth of Pennsylvania Blue Shield and to hear of the progress being made in claims processing and of other Blue Shield activities. Blue Shield should be encouraged to continue its development of plans which will meet the rapidly changing health care needs of the future.

I move the adoption of this portion of the reference committee report.

Pennsylvania Blue Cross Plans

Your reference committee approves of the efforts of the Council in the development and functioning of Regional Blue Cross Physician Advisory Committees. The guidelines for the organizational structure of the PMS—Blue Cross Regional Steering Committee developed by the Council and established on a pilot basis in western Pennsylvania appear to be particularly well conceived. The Council is to be commended for its efforts in this area.

I move the adoption of this portion of the reference committee report.

Pennsylvania Medical Society Review Program and Address of President—Peer Review

The revised review program should greatly improve the Society's capacity for handling disputed fee cases and utilization problems presented by third party carriers and the Council is to be commended for its efforts.

Your reference committee concurs with the intent of the president's recommendation regarding peer review and we feel the present review program provides an opportunity for

county medical societies to participate in these activities. The present mechanisms for evaluation of factors affecting the cost and quality of health care in hospitals are the responsibility of each medical staff and your reference committee recommends that each hospital medical staff be urged to develop and expand its capability to handle this responsibility.

I move the adoption of this portion of the reference committee report.

Malpractice Insurance and that portion of the Council's Supplemental Report dealing with Malpractice Insurance and Section of Report of Board of Trustees Re Malpractice Insurance

The increase in premiums and difficulty in obtaining professional liability insurance is one of the most important problems with which we are faced today. Your reference committee applauds the Council's interest in this problem and, while it appears that little progress has been made to date, your reference committee urges continued emphasis and investigation by the Council.

Commission on Comprehensive Health Planning and the President's Address —Section J—Health Planning (Published in November, 1969, PENNSYLVANIA MEDICINE)

Your reference committee notes that the Commission on Comprehensive Health Planning has been active in pursuing its duties and we commend the Commission and Council staff.

Society Endorsed Insurance Programs

Your reference committee commends the Council for its efforts to improve the group insurance programs available to our membership and urges the continuation of these activities.

Addendum to President's Address— National Health Care

Your reference committee suggests that the president's recommendation concerning preparation in advance for any system of national health care be referred to the Council on Medical Service for further study and consideration.

I move the adoption of this portion of the reference committee report.

Report of Committee on Objectives Re Delivery of Medical Services (Official Reports Booklet, Page 69)

Your reference committee recommends that the appropriate administrative Councils continue to study the development of trends in delivery of medical services which have been identified by the Committee on Objectives so that they may be taken into consideration in the formulation of future Society policy.

I move the adoption of this portion of the reference committee report.

Resolution 69-3: Blue Shield Reorganization (Official Report Booklet, Page 125)

WHEREAS, Blue Shield has traditionally been known as the Doctor's Plan; and

WHEREAS, There is an ever increasing desire by the Blue Cross plans to pay for more and more physicians' services; and

WHEREAS, In Pennsylvania, Blue Shield coverage is sold mainly by other insurance carriers which are predominately hospital oriented; and

WHEREAS, this method of operation lends to the confusion over hospital costs and doctors' fees and in some cases restricts the sale of Blue Shield coverage; therefore be it

Resolved, That the Pennsylvania Medical Society recommend to the Medical Service Association of Pennsylvania (Pennsylvania Blue Shield) that it assume an autonomous corporate operation and identity with respect to its governing board, its sales force and its public relations effort in Pennsylvania.

While realizing that ideally, complete separation of Blue Shield and Blue Cross seems desirable, this Resolution seems impracticable. It would lead to increased costs which would have to be borne by subscribers and these costs would not bring about improvement in patient care.

I move the rejection of Resolution 69-3.

Resolution 69-4: Blue Cross Payment of Physicians' Fees and (Official Reports Booklet, Page 125)

WHEREAS, The Blue Cross plans have traditionally been and are today a hospital insurance carrier; and

WHEREAS, The practice by Blue Cross of paying physicians' fees has created confusion in the minds of the public and has contributed toward misunderstanding among hospital-based specialty groups; therefore be it

Resolved, That the Pennsylvania Medical Society recommend to the Blue Cross plans of Pennsylvania that they stop the practice of paying physicians' fees; and be it further

Resolved, That the Pennsylvania Medical Society recommend to the Medical Service Association of Pennsylvania (Pennsylvania Blue Shield) that it establish procedures which will place all physicians' fees, and particularly those now paid by Blue Cross, under their plans.

Resolution 69-40: Radiology Services in Blue Shield (in Delegates Packet)

WHEREAS, Blue Cross was developed to pay hospital costs and Blue Shield developed to pay physician's fees; and

WHEREAS, Some radiology services in Pennsylvania hospitals are paid through Blue Cross, and these radiologic fees usually include the professional fees of the radiologist; now therefore be it

Resolved, That the Pennsylvania Medical Society request that the Blue Shield develop a comprehensive fee schedule for radiologic professional services to be paid through all Blue Shield contracts; and be it further

Resolved, That the five Blue Cross plans of Pennsylvania be requested to discontinue the payment of physician fees to hospitals; and be it further

Resolved, That the Insurance Commissioner of Pennsylvania be requested to implement this by granting a decrease in Blue Cross rate schedule and a corresponding increase in Blue Shield's rate schedule.

Because of their similarity, these two resolutions were considered together. Your reference committee supports the philosophy of fee for service for physicians but recognizes the necessity of negotiation on a voluntary basis by physicians with the administration of the institution in which they practice. Since Blue Cross pays only physician ancillary services and since Pennsylvania Blue Shield is willing to

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Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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pay fees for service by a physician, this Resolution seems inappropriate.

I move the rejection of Resolution 69-4 and Resolution 69-40.

After considerable discussion, the House voted not to accept the recommendation of its reference committee and instead adopted both Resolutions 69-4 and 69-40.

Resolution 69-5: Blue Shield Coverage of Physicians' Fees for Out-Patient Treatment (Official Reports Booklet, Page 125)

WHEREAS, The Blue Shield plans have been known as the Doctors' Plans; and

WHEREAS, The greatest area of misunderstanding exists in out-patient physician fees; and

WHEREAS, Some of these fees are now covered by Blue Shield and some by Blue Cross; therefore be it

Resolved, That the Pennsylvania Medical Society will recommend to the Medical Service Association of Pennsylvania (Pennsylvania Blue Shield that mechanisms be developed whereby all out-patient fees should be covered.

Since Blue Cross is not paying out-patient fees and Blue Shield has mechanisms in existence which do pay out-patient fees, this resolution seems inappropriate.

I move the rejection of Resolution 69-5.

Resolution 69-6: Special Hospital Funds (Official Reports Booklet, Page 125)

WHEREAS, From time to time special funds which have existed in hospitals in the State of Pennsylvania have created problems with their formation and operation; and

WHEREAS, The Judicial Council of the Pennsylvania Medical Society has recently set forth guidelines for hospital medical staffs in Pennsylvania; and

WHEREAS, These guidelines set forth, very clearly, the manner in which fees for medical treatment are to be applied to these special funds as well as the manner in which these funds are to be administered by the medical staff; therefore be it

Resolved, That the Pennsylvania Medical Society call upon the AMA House of Delegates to adopt these guidelines and to make them a part of the Principles of Medical Ethics.

Resolution 69-19: Reaffirmation of "Sole Arbiter" Position (Official Reports Booklet, Page 129)

WHEREAS, The House of Delegates of the Pennsylvania Medical Society in September 1967 adopted Resolution 67-14 which reaffirmed the guidelines which the American Medical Association had established for the payment for physicians' services; and

WHEREAS, This same Resolution states the House of Delegates' opinion that an individual physician may not be deprived of his right by a vote of the medical staff or medical board of a hospital to be the "sole arbiter" of the disposition of his professional income; and

WHEREAS, The Judicial Council of the Pennsylvania Medical Society, in an opinion rendered after its hearing in Philadelphia on January 10, 1969, stated "it is ethical for a medical staff to adopt a resolution which requires all members of the staff to donate a percentage of third party payments to a hospital fund, educational fund, teaching fund, etc . . ."; and

WHEREAS, In this same opinion the Judicial Council stated, "It is important, also, to remember that your Council continues to recognize that the physician is, in the final analysis, 'the sole arbiter of his income', for, if a physician is unwilling to support such a fund when same is established by a majority vote of the medical staff, he can, as a matter of absolute right, relocate"; therefore be it

Resolved, That the House of Delegates, Pennsylvania Medical Society, reaffirms Resolution No. 67-14; and be it further

Resolved, That the House of Delegates of the Pennsylvania Medical Society disagrees with the Judicial Council's interpretation of the American Medical Association guidelines as they pertain to the right of the individual physician to be the "sole arbiter" of the disposition of his professional income; and be it further

Resolved, That the House of Delegates, Pennsylvania Medical Society, strongly recommends that the Judicial Council reconsider its interpretation of these guidelines and issue its opinion at the earliest possible date.

These resolutions were considered together. Since they are contradictory and since there exists a question regarding interpretation of AMA guidelines by the Judicial Council, your reference committee recommends adoption of Resolution 69-19 and that action be tabled on Resolution 69-6.

I move the adoption of Resolution 69-19.

I move that Resolution 69-6 be postponed indefinitely.

Resolution 69-7: Physician Membership on Hospital Boards of Directors and (Official Reports Booklet, Page 126)

WHEREAS, Physicians have a responsibility to provide quality medical care to their patients; and

WHEREAS, This care is frequently provided in a hospital setting; and

WHEREAS, Physicians should accept their share of the responsibility of the problems of hospital operation; therefore be it

Resolved, That the Pennsylvania Medical Society continue to recommend to all hospital boards of directors, the advisability of appointing, as active voting members of the hospital boards, physicians who are on their medical staff; and be it further

Resolved, That the Pennsylvania Medical Society recommend to the AMA representatives to the Joint Commission on Hospital Accreditation, the requirement that one or more representatives of the medical staff of the hospital be named as voting members to the board of directors.

Resolution 69-26: Physicians on Hospital Governing Boards (Official Reports Booklet, Page 131)

WHEREAS, Hospitals are held in trust for the community they serve by members of their governing boards; and

WHEREAS, Physicians by training and experience are best qualified to understand the medical needs of the community; and

WHEREAS, The House of Delegates of the American Medical Association and the American Hospital Association have approved in principle a resolution recommending adequate representation of practicing community physicians on the governing boards of community hospitals; now therefore be it

Resolved, That the Pennsylvania Medical Society recommend to the governing boards of Pennsylvania hospitals, the Hospital Association of Pennsylvania and the Philadelphia Hospital Council that governing boards of accredited Pennsylvania hospitals have adequate representation of physicians with voting privileges; and be it further

Resolved, That such physician representatives be elected by the hospital's medical staff.

Resolutions 69-7 and 69-26 are similar and were considered together. These resolutions differ in the mechanisms by which physicians should obtain hospital board membership. To clarify this question, the reference committee offers the following substitute resolution:

"*Resolved,* That the Pennsylvania Medical Society recommend to the governing boards of Pennsylvania hospitals, the Hospital Association of Pennsylvania, and the various hospital councils in Pennsylvania that governing boards of accredited Pennsylvania hospitals have adequate representation of physicians with voting privileges; and be it further

"*Resolved,* That such physicians be appointed by the boards from nominees suggested by the medical staff.

"*Resolved,* That the Pennsylvania Medical Society recommend to the AMA Representatives to the Joint Commission on Hospital Accreditation, the requirement that one or more representatives of the medical staff of the Hospital be named as voting members to the Board of Directors."

I move the adoption of the substitute resolution as amended.

Resolution 69-11: An Adequate Pennsylvania Blue Shield Consultation Program (Official Reports Booklet, Page 127)

WHEREAS, Consultation service is an integral part of today's medical practice; and

WHEREAS, Modern consultation practice involves not only the combination of general practitioner and specialist; and

WHEREAS, Serious illness often requires the service of multiple consultants; and

WHEREAS, The majority of present day Blue Shield Plans (Plans A, B, and certain prevailing fees programs, such as the Master Steel Contract) provide extremely limited coverage for single consultations and no coverage for multiple consultations; therefore be it

Resolved, That the Pennsylvania Medical Society urge the Medical Service Association of Pennsylvania (Pennsylvania Blue Shield) to review its current consultation program of comprehensive coverage for consultation service in all its plans, particularly recognizing the service of multiple consultations; and be it further

Resolved, That Pennsylvania Blue Shield provide adequate compensation to cover such a comprehensive consultation program.

Resolution 69-13: Blue Shield Consultation Coverage, (Official Reports Booklet, Page 127)

WHEREAS, Consultation between physicians is an important aspect of the practice of medicine today; and

WHEREAS, Not only do general practitioners consult with specialists, but specialists frequently consult with subspecialists; and

WHEREAS, Serious illnessess frequently require several consultations; and

WHEREAS, Currently Blue Shield Plans only make allowance for a single consultation, providing no coverage for multiple consultations; therefore be it

Resolved, That the Pennsylvania Medical Society urge Pennsylvania Blue Shield to review its consultation program with the intent of developing comprehensive coverage for consultation service in all Plans, and to recognize particularly multiple consultation services; and be it further

Resolved, That Pennsylvania Blue Shield provide an adequate fee schedule to cover such various consultations.

Resolution 69-16: Coverage of Consultation Service by Pennsylvania Blue Shield (Official Reports Booklet, Page 127)

WHEREAS, Consultation service is an integral part of today's medical practice; and

WHEREAS, Modern consultation practice involves not only the combination of general practitioner and specialist, but also specialist and subspecialist; and

WHEREAS, Serious illness often requires the service of multiple consultants; and

WHEREAS, The majority of present day Blue Shield plans (plans A, B and certain prevailing fees programs, such as the Master Steel contract) provide extremely limited coverage for single consultations, and no coverage for multiple consultations; therefore be it

Resolved, That the Pennsylvania Medical Society urge Pennsylvania Blue Shield to review its current consultation program with the intent of developing a program of comprehensive coverage for consultation service in all its plans, particularly recognizing the service of multiple consultations; and be it further

Resolved, That Pennsylvania Blue Shield provide an adequate fee schedule to cover such a comprehensive consultation program.

Resolution 69-24: Blue Shield Consultation Program (Official Reports Booklet, Page 130)

WHEREAS, Consultation between physicians is one of the most important aspects of medical practice; and

WHEREAS, Not only do general practitioners consult with specialists, but consultation may be needed with more than one specialist and sometimes with subspecialists; and

WHEREAS, Most Blue Shield plans currently available make allowance for a single consultation only, frequently providing no coverage for multiple consultations nor for further specialized care following consultation; therefore be it

Resolved, That the Pennsylvania Medical Socicty urgc Pennsylvania Blue Shicld to reviow its current program for consultations and provide an adequate fee schedule for multiple consultations and for specialist care when such consultation or care is indicated.

Because of their similarity, Resolutions 69-11, 19-13, 69-16, and 69-24 were considered together and the need is recognized for multiple consultation payments. Because of cost implications, it does not seem suitable that Blue Shield be requested to develop coverage for consultation services in all of its plans. Accordingly, the following substitutc resolution is offered:

"*Resolved,* That the Pennsylvania Medical Society request the Medical Service Association of Pennsylvania to review its current consultation program to explore the feasibility of providing adequate coverage for multiple consultation."

I move the adoption of this substitute resolution as amended.

Resolution 69-14: Medicredit System (Official Report Booklet, Pages 127-128)

WHEREAS, The growth and development of bank cards, credit cards and other similar systems of paying medical bills have been widely introduced by reputable financial institutions and business organizations; and

WHEREAS, The medical profession has officially recognized that it cannot dictate to patients how they shall finance their medical bills; and

WHEREAS, The Judicial Council of the American Medical Association is of the opinion that physicians' participation in credit card programs is to be considered a recognized medium of exchange and is not per se unethical; and

WHEREAS, Recently in certain areas of Pennsylvania the Medicredit System has initiated a working arrangement between the medical profession, banking community and the insurance industry which deserves recognition as an acceptable method to meet financial medical obligations; therefore be it

Resolved, That the Berks County Medical Society hereby encourages the Pennsylvania Medical Society to advise all physician members that it is ethically acceptablc to use the Medicredit System or similar medical credit cards when specifically requested to do so by the patient; and be it further

Resolved, That neither the individual county medical societies nor the Pennsylvania Medical Society officially approves or disapproves Medicredit or any other similar system but leaves the decision of accepting the use of these systems to each individual physician and patient; and be it further

Resolved, That the physicians of the societies may not use the plans to solicit patients or encourage any of the patients to use a specific method of payment, his position being that the physician accepts the plan as a convenience to the patients who desire to use it; and be it further

Resolved, That the individual physician will be expected to continue the traditional practice of rendering services to all those who need them regardless of their ability to pay or permitting patients of limited means to pay relatively large fees in convenient installments without any carrying charges.

Your reference committee has considered Resolution 69-14 and has received correspondence from the sponsors of this resolution that they wish to withdraw it. Accordingly, no action is recommended on this resolution.

I move that thc withdrawal of Resolution 69-14 be approved.

Resolution 69-20: Reimbursement for Radiology Services (Official Reports Booklet, Page 129)

WHEREAS, The present basis of co-pay reimbursement for radiologic services based on the 1958 Blue Shield fee schedule is inadequate; and

WHEREAS, There are inequities in the present reimbursement of different radiologists in different situations (private office, hospital, etc.) for comparable procedures; therefore be it

Resolved, That the House of Delegates of the Pennsylvania Medical Society recommend to the Blue Cross of Greater Philadelphia and to Pennsylvania Blue Shield that action can be taken promptly to establish realistic, up-to-date standards of reimbursement, preferably through Blue Shield, for radiologic services and that these be equally available to all radiologists.

Thc rcference committee has considered Resolution 69-20 and agrees with the intent of the resolution. In order to clarify the meaning of the "*Resolved*", the reference committee recommends deletion of the word "can" from line 4 and the word "preferably" from line 6 of the "*Resolved*" and recommends the adoption of this resolution as amended.

Resolution 69-30: Blue Shield Coverages of Non-Physicians (Official Reports Booklet, Page 132)

WHEREAS, It is in the public interest to broaden Blue Shield coverage to encourage early medical treatment by the utilization of office medical services and avoidance of in-patient hospital services and hospitalization is not medically necessary; and

WHEREAS, The U. S. Department of Health, Education and Welfare, in a report to Congress, has stated: "The safety of the patient and the appropriation of the services provided to him are most adequately assured if his point of entry into this health care system is the physician—the practitioner with the broadest knowledge and the greatest skill in diagnosis and evaluation of the patient's total health status and needs"; and

WHEREAS, There is no non-physician service that is the equivalent of the service of a physician licensed to practice medicine and surgery; therefore be it

Resolved, That the public interest requires that any Blue Shield coverage provide specifically for physicians' services for all subscribers, and that if any Blue Shield Plan issues coverage for the services of any non-physician practitioners, such coverage be only for services prescribed or ordered by a physician and rendered under his direction.

The reference committee agrees with thc intent of the resolution but believes that effective implementation might provoke public reaction against physicians and recommends the rejection of Resolution 69-30.

I move the rejection of Resolution 69-30.

Resolution 69-31: National Group "Umbrella" Insurance Study (Official Reports Booklet, Page 132)

WHEREAS, The cost of malpractice insurance payments has increased markedly in the past decade; and

WHEREAS, All physicians have need for extensive insurance coverage such as health, accident, life, liability, fire, theft, car and retirement plans; and

WHEREAS, The members of the American Medical Association are among the largest purchasers of insurance; and

WHEREAS, Group insurance coverage offers many advantages in cost, protection, etc.; therefore be it

Resolved, That the Pennsylvania Medical Society House of Delegates forward to the American Medical Association's House of Delegates the desirability of appointing an insurance committee (special or regular) whose purpose would be to study the practicality, cost, protection and feasibility of an "umbrella type" coverage for all members of the American Medical Association.

Your reference committee recognizes the desirability of umbrella type coverage for physicians and recommends the adoption of Resolution 69-31.

I move the adoption of Resolution 69-31.

Resolution 69-36: Medicare and Medicaid Investigations

WHEREAS, The members of the Dauphin County Medical Society were disturbed to learn of the statement attributed to the U.S. Government which called for the Internal Revenue Service to investigate all physicians who receive more than $25,000 in "Medicaid" or "Medicare" fees; and

WHEREAS, Such a statement tends to imply that anyone receiving this sum of money from "Medicaid" and "Medicare' services is allegedly violating the income tax laws; and

WHEREAS, There has been no violation of the law relating to "Medicaid" or "Medicare" in Pennsylvania reported to the Pennsylvania Medical Society, which would indicate that the medical profession of this Commonwealth is guilty of any wrongdoing; therefore be it

Resolved, That the Pennsylvania Medical Society inquire of the Department of Health and Public Welfare of the Commonwealth of Pennsylvania as to whether or not any physician of this Commonwealth, upon investigation by it has in any way defrauded the state government and/or federal government, and, if so, that the departments inform the Pennsylvania Medical Society about these individuals and if they are members of the Society that a full investigation concerning their conduct be undertaken, and if necessary, appropriate steps be taken to discontinue this wrongful practice if it exists; and be it further

Resolved, That, if this investigation shows there is no wrongdoing on the part of member physicians of the Pennsylvania Medical Society in relation to "Medicare" and "Medicaid" programs, the results of this investigation be directed to the Department of Health, Education and Welfare of the United States Government with an appropriate letter of transmittal to indicate Pennsylvania Medical Society's displeasure with the tactics being employed against them.

Resolution 69-38: Adverse Publicity on Medicare and Medicaid

WHEREAS, The medical profession has been subjected to adverse criticism for overcharges for Medicare and Medicaid patients; and

WHEREAS, The criticism deals with general and blanket charges of abuse as well as overcharges by physicians; and

WHEREAS, Statements issued by these agencies reflect upon the integrity of all physicians; therefore be it

Resolved, That the Pennsylvania Medical Society advise the Secretary of the Department of Health, Education and Welfare and Blue Shield of Pennsylvania that the Pennsylvania Medical Society has in the past and will continue to work with these agencies to correct abuses; and be it further

Resolved, That the intent of this resolution be presented at the House of Delegates of the American Medical Association; and be it further

Resolved, That a copy of this resolution be sent to President Richard M. Nixon and the Senate Finance Committee.

Because of their similarity, Resolution 69-36 and Resolution 69-38 were considered together. The reference committee considers both these Resolutions of value and finds that Resolution 69-36 is somewhat more comprehensive. However, the reference committee believes that certain amendments are in order and recommends the following as a substitute resolution:

"WHEREAS, The U. S. Internal Revenue Service has been directed to investigate all physicians who receive more than $25,000 in "Medicaid" or "Medicare" fees; and

"WHEREAS, Such a statement implies that anyone receiving this sum of money from "Medicaid" and "Medicare" services is guilty of wrongdoing; therefore be it

Resolved, That the Pennsylvania Medical Society inquire of the Department of Public Welfare of the Commonwealth of Pennsylvania and the U. S. Department of Health, Education and Welfare whether or not any physician of this Commonwealth, upon their investigation has in any way defrauded the state government and/or federal government, and, if so, that the departments inform the Pennsylvania Medical Society about these individuals, and if they are members of the Society that a full investigation concerning their conduct be undertaken, and if necessary, appropriate steps be taken to discontinue this wrongful practice if it exists; and be it further

Resolved, That, if this investigation shows there is no wrongdoing on the part of member physicians of the Pennsylvania Medical Society in relation to "Medicare" and "Medicaid" programs, the results of this investigation be directed to the appropriate departments to indicate Pennsylvania Medical Society's displeasure with the tactics being employed against them."

I move the adoption of the substitute resolution as amended.

Annual Assessment

Park M. Horton, M.D., chairman of the Finance Committee of the Board of Trustees and Councilors, presented the following report, which was adopted by the House of Delegates, thereby establishing the annual assessment for 1970 at $75:

Mr. Speaker, Members of the House of Delegates, the Finance Committee recommends that the 1970 Annual Assessment for active members of the Pennsylvania Medical Society be $75.

Contingent upon the approval by the House of the 1970 Assessment, the Finance Committee plans to introduce a resolution before the Board of Trustees which will recommend that 10.667 percent of the Annual Assessment be allocated to the Educational Fund of the Educational and Scientific Trust of the Pennsylvania Medical Society, which, in the case of full-dues paying members will amount to $8.00.

The Finance Committee also plans to recommend to the Board of Trustees that of the Annual Assessment paid by each active member, 1.33 percent, or in the case of full-dues paying members $1.00, be allocated to the Medical Benevolence Fund.

This means that rather than $75, a total of $66 of the Annual Assessment of each full-dues paying member will be available to the General Fund for the operating expenses of the Society.

The House Recognizes The Speaker And Vice-Speaker

Raymond C. Grandon, M.D., Dauphin County, moved that the House give a rising vote of thanks to the Speaker and Vice-Speaker for the manner in which they conducted the meeting. The Delegates signified their approval by standing.

William Y. Rial, M.D., Speaker
John B. Lovette, M.D., Vice-Speaker
Allen W. Cowley, M.D., Secretary
Robert L. Lamb, Assistant Secretary

Appendices

APPENDIX A

Remarks of the President-Elect Pennsylvania Medical Society

WILLIAM A. BARRETT, M.D.
Pittsburgh

Mr. Speaker, Mr. President, Members of the Board of Counselors and Trustees, members of the House of Delegates, ladies and gentlemen. I am honored by the confidence you have shown in electing me to the high office of president-elect of the Pennsylvania Medical Society. I am grateful to the members of the House of Delegates and to the physicians of Pennsylvania for this opportunity to serve the medical profession and, through you, the general public of this commonwealth.

In accepting this assignment you must realize that I do so with mixed emotions. Each of us deeply regrets the unfortunate set of circumstances which impelled Dr. Carl B. Lechner to resign from this office to which you elected him one year ago. Because of his experience in medical affairs in general as Editor of PENNSYLVANIA MEDICINE and his great integrity, no one can replace him in this Society or in our hearts.

Even if I had had a year in which to prepare this address, I could not have suggested to you an answer to all of

WILLIAM A. BARRETT, M.D.

our problems; I do not even know all of the questions.

However, there are at least six subjects which urgently demand our attention. Each of us must direct his time and effort toward a solution of these problems: (1) the great shortage of physicians; (2) the uneven distribution of physicians throughout the State; (3) a continuing education of physicians; (4) the training and certification of paramedical groups; (5) justification for the increased medical care costs; (6) direction and guidance of federal health programs.

I. THE SHORTAGE OF PHYSICIANS

For years the medical profession has worked hard to educate the public on matters of health. This has been by word of mouth, school programs, newspaper articles, lectures, radio and television programs. It has been effective and helpful. This has been good for millions of people through the great advances in food production and food handling, housing, environmental control, drugs, and immunological vaccines and in many other scientific fields but especially in the field of preventive medicine.

We have increased the health education of the public which, together with an unprecedented affluence, has created a demand for health care and health facilities far beyond our available manpower. But our medical schools have not expanded their capacity to train physicians. Many schools have not increased their student enrollment in the first two years

more than five per cent to eight per cent over the past fifty years. This has not been because of a scarcity of interested, educated young people willing to spend long years in the study of medicine. The medical school is a bottleneck in the provision of medical care to patients.

Two primary reasons are given by the schools for not expanding their facilities,—the costs of physical plant construction and the availability of teachers. Unquestionably, these are the primary reasons and both could be cured with adequate grants or appropriations.

The real bottleneck has been laboratory space in some of the basic sciences of the first two years. Some changes *have* been made. But, with the great need for more physicians and with the unbelievable advances in automation, the "cook book" courses must be critically evaluated.

The great costs of constructing laboratories for training students in the basic sciences is well recognized. The rapidly increasingly costs of construction make it less likely that private philanthropy will be able to do it in the future. Teachers can be trained and, when the inducements, including salaries, are adequate, the supply will be forthcoming.

Many teachers of the basic sciences in medical schools actually teach no more than half of the school year. Many of these are engaged in research and do contribute worthwhile extensions to the medical horizons,—this with the assistance of large grants which also contribute about 60 per cent to the overhead costs of the school. Research is, of course, a very important leg on the stool. But the primary purpose of the medical school is to train physicians to provide medical care to patients.

In the past forty years the number of accredited medical schools has increased from 72 to 101. But this has not been comparable to the population expansion or to the increased services demanded by individual patients.

Medical school facilities must be expanded to train three times the present enrollments. The funds with which to do this must be provided by state and federal appropriation, as well as through private philanthropy.

Teaching programs in community hospitals should be developed and utilized for the clinical training of advanced medical students. This has been successfully tried in one school and has greatly expanded the student education potential. The unprecedented need demands some further experimentation with a tremendous untapped pool of clinicians.

Double or better still, triple the present number of physicians practicing today and the old law of "supply and demand" will quickly provide the needed medical care, maintain a high quality of service and answer night calls. Competition is a powerful stimulus.

Rather than legislating great sums of money for bureaucratic programs of government controlled medicine and huge sums for vague programs in research, (The National Institutes of Health are spending $1.93 billion in 1969) relatively insignificant programs of construction and support for enlarging our present 101 medical schools could double the output of physicians in ten years.

This Society should convince the legislators of Pennsylvania and the Congress of the United States that such an expansion of physician training programs is absolutely essential regardless of the system of medical care.

II. DISTRIBUTION OF PHYSICIANS

The uneven distribution of physicians throughout the state, and the country, has been primarily on an economic basis. In addition, the surroundings, schools, leisure-hour attractions and conviences for the family have been important factors in each physician's determination of where he wishes to practice and live. He has the right to make this decision. Some areas *are* less attractive.

The Council on Public Service has made a worthwhile, positive suggestion for the Educational and Scientific Trust which would, in effect, help the Pennsylvania Medical Society to subsidize medical practice in an area of great need.

The Society through its Trust gave four full-tuition medical school scholarships for the entire medical school period. Many of those students have had alternate means of financing their education. Of the sixty-eight scholarships and loans so provided only three are now practicing in Pennsylvania.

The Educational and Scientific Trust has efficiently and commendably distributed, in scholarships and loans, moneys provided from the dues of our members. This has been with "no strings attached" in the past. Without additional costs or expenditures these same funds can be used to help supply medical care to some of our neglected communities.

The Council has recommended that some of the indebtedness of these recipients be forgiven for each year they practice in one such community. This should be an added inducement to young physicians. Your dues dollars would thereby perform two worthwhile services instead of one.

This serious problem of our times demands that we reevaluate an outdated philanthropic philosophy.

All money allocated to scholarships and loans to medical students in the future, and similar loans made in the past, should be disbursed with the provision that each new physician, who practices in one of the communities listed by the Pennsylvania Medical Society, shall have his indebtedness reduced by not more than twenty per cent for each year that physician continues to serve the area in full time private practice.

III. CONTINUING EDUCATION OF PHYSICIANS

The continuing education of physicians has recently been stressed by many. The many great advances in all fields of medical science and in every discipline make continued study and training imperative in the best interest of patients. It is also in the best interest of physicians whose lives are dedicated to continuous learning as well as continually serving.

Every branch of medicine has its meetings, conferences and seminars but only the minority of each group actually attend. Regardless of the reasons for not attending, the scientific advances must be gotten to the vast majority. Since many will not go to the meeting centers, courses must be provided in local communities and hospitals for those physicians who most need them.

Only the Pennsylvania Medical So-

ciety is in a position to provide the leadership necessary to coordinate all efforts throughout the State. All seven medical schools, clinics, teaching hospitals and county medical societies must forget their institutional pride, provincialism and self-aggrandizement in a sincere effort to provide the programs physicians need. Every specialty society must participate.

With proper overall coordination, wasteful overlapping of planning activities, personnel and costs should be minimized; the programs provided should be of the highest calibre; the individual identity of the teachers and institutions would not be lost; the programs would be taken in to the areas of need and to those individuals who do not go out to the large centers.

Regional medical programs are devised to help accomplish these objectives and should be the best sources of funds and personnel to accomplish these ends. The Pennsylvania Education and Scientific Trust, the various foundations, pharmaceutical companies and private philanthropy should be urged to support this program financially and on a continuing basis.

This role of the Council on Education and Science, as viewed by the Long Range Planning Committee, is a clear cut, concise outline for the continuing education of physicians. I congratulate the committee and urge each member of this Society to read their recommendations.

IV. PARAMEDICAL ASSISTANCE

The teaching and utilization of various types of paramedical assistance has too long been neglected. All physicians take for granted the various roles played by the nursing profession; many are familiar with the value and help of laboratory and x-ray technicians. Excepting for corpmen in the armed services few physicians have had experience with any other type of medical assistance.

With the great shortage of physicians there is an urgent need to expand the effectiveness of each physician, whether in teaching centers or in rural areas. Use physicians in the services for which they have been trained. There is a wealth of available manpower which, properly trained and utilized, *can* relieve some of the physician shortage. Programs, teaching certification and utilization can provide many needed paramedical assistants. They *can* perform many services that pediatricians, obstetricians, urologists, general practitioners and others, as well as registered nurses now do.

Pennsylvania physicians must exert the leadership needed to expand our effectiveness and provide service through these channels.

V. FEDERAL HEALTH PROGRAMS

Federal health programs are here to stay. Physicians have made the medicare program a success and are presently learning to live with the medicaide program. This we must do to permit our patients to take proper advantage of the provisions of these laws. Most physicians are annoyed by the nuisances and paper work involved but, under Titles XVIII and XIX, much of the physician care provided to patients is paid for.

Regional medical programs are being developed in every section of the state to more speedily deliver and more effectively provide the scientific advances learned in the experimental laboratory. It is inherent in the law that these advances be more rapidly available to patients and physicians. Expectantly, this will continually improve the quality and quantity of good medical service received by more patients. This will continue to advance our health care system.

But more of our physicians must become involved in the regional medical programs of heart, cancer and stroke —P.L. 89-239 and in the comprehensive health planning, —P.L. 89-749. These all-inclusive government programs will affect all patients and all physicians and eventually control every aspect of health and health care.

Physicians in every community must *assist* in the formulation of these plans and programs, must participate in their administration.

No longer is it proper, appropriate or advisable for any physician to remain aloof from the world around him. Formerly, many honest and capable medical men insisted that others could concern themselves with regulations, government politics and programs, insurance plans and "medical politics." Of course, as in the past, our primary activities and interests must be in the scientific endeavors and in the care of the patients. This is the reason for which we went to medical school we dare not be "too busy" to become knowledgeable concerning the programs that can help our patients.

Neither should we, through silence or inactivity, refuse to support the "voice" of the Pennsylvania Medical Society and the American Medical Association in the councils and legislative halls. To protect the interests of our patients the voluntary system of medicine, under which we serve, must be preserved. We must move forward not backward. No one stands still.

VI. QUALITY AND COST OF MEDICAL CARE

Since before the time of Hippocrates in 460 B.C., the medical profession has always taken unto itself the responsibility of providing the best possible medical care. The profession has been known for its intellectual background, integrity and self sacrifices. The gradually increasing periods of training, required by physicians themselves, has been an effort to improve the quality of medical care commensurate with the advances in medical sciences.

The accreditation of our medical schools and our hospitals are forms of peer review which were established only by the profession.

Tissue committee review, medical records committees and utilization review committees are more recent improvements in the attempt to provide the best possible medical care to patients. The continuing education of the physician is probably the most recent addition to this system.

The utilization review committees are primarily an educational program intended to make each physician aware of the day-to-day costs of the tests and treatments he has ordered for each patient. Each day of delay in the hospital, each unnecessary laboratory test or x-ray, each failure to synchronize the date of admission with the necessary tests prior to surgery and each failure to anticipate the checkout time for discharge contribute to the unnecessary costs of providing physicians' and hospital services to that patient. Such hospital services, if used unnecessarily, increase the total cost to the patient or his insurance program

and to that extent the cost is inflated regardless of who is paying the bill—to that extent insurance premiums are increased for everyone. Only physicians admit patients to hospitals, order the tests and treatment and discharge the patient. Watch those orders!

Physicians do recognize and accept this responsibility. They must exert every effort to control the costs of services over which they exert any influence. The utilization review committees act for the staff, as a whole, to highlight unrecognized areas for improvement or recalcitrant repeaters and must be supported.

Hospital costs have reached an intolerable level. The situation has become critical. The public is becoming restless.

The old system in which physicians, especially house staff, ordered every test and x-ray without thought or consideration of cost, is just not working.

Mr. Robert H. Finch, secretary of Health, Education and Welfare has said that "our task as a nation is to acknowledge the extreme urgency of the situation, to take certain steps to arrest the medical inflation that is paralyzing us and to put into motion initiatives that ultimately will reshape the system."

"Too often the private sector has been reluctant to give up outmoded practices that are unsuited to the incredibly rapid changes for our society—to new demands, and increased demands."

Legislatures and other government officials are beginning to forcefully attack this problem in the health industry. The government now has in the form of medicare and medicaide the means of forcing needed changes. The government has considered overhauling the whole system but presently seeks cooperation from the health industry.

Secretary Finch has said "what is ultimately at stake is the pluralistic, independent, voluntary nature of our health care system. We may lose it to "the pressures for monolithic, government-dominated, medical care unless we can make that system work for everyone in the nation."

Let us alert every physician to these unbridled costs of medical care and let each physician in the Commonwealth of Pennsylvania appoint himself a committee of one to control these costs in his practice.

The quality of leadership is inherent in every physician. You are the leaders in your community else you would not be sitting here as members of this House of Delegates. Join me in promoting the Pennsylvania Medical Society programs at your county society levels. With your assistance and the guidance of the Lord, we shall seek solutions to these problems in the coming year.

APPENDIX B

Remarks of the President Woman's Auxiliary to the Pennsylvania Medical Society

MRS. AXEL K. OLSEN

To The House of Delegates:

Dr. Farrar, Dr. Rial, officers, members, and guests of the Pennsylvania Medical Society's House of Delegates:

The opportunity to report the activities of the Woman's Auxiliary to the Pennsylvania Medical Society is greatly appreciated.

Membership for the year totaled 5,840. Of the fifty-seven organized county auxiliaries, twenty-seven now actively participate in "Voluntary Joint Billing."

Emphasis was placed on community awareness and general concern for children and youth. In an age where nuclear involvement and space exploration are becoming increasingly important, the strenuous efforts and dedication of Auxiliary members for community affairs are deserving of the highest commendation.

The Auxiliary has encouraged its members to cooperate with existing agencies and service clubs in order to prevent duplication of effort and to provide the proposed projects with additional strength and support. Medical and hospital auxiliaries are closely allied in many communities.

A "Know Your Community" study packet, including directives and a bibliography, was introduced. Books, package programs, and reference materials are on loan from the newly-established library located in the State office.

More than fifty counties assumed the responsibility for at least one major community project, which ranged from working with the pre-school child to visiting a senior citizen. Many groups planned a "Know Your Community" month. The related activities included: visits to hospitals, children's homes, a well-baby clinic and health centers and a tour of a newspaper plant. Several prominent citizens also participated. A mayor spoke on community affairs, a director of child welfare services explained his program, and various speakers discussed the teamwork between county welfare and the physician and problems typical of youth in a detention home. One county discovered a need for financial aid and tools for a sheltered workshop for the handicapped.

Auxiliary members throughout Pennsylvania are working and cooperating on projects with local medical societies. Assistance was given to physicians in health fairs, immunization programs, diabetic detection clinics, visual and hearing screening tests, and with blood banks. TODAY'S HEALTH, pamphlets, and posters were placed in doctors' offices, schools, and libraries. One county provides service by tabulating the votes at the annual election of medical society officers.

The "Package Programs" developed by the Woman's Auxiliary to the American Medical Association continue to prove valuable in health education. Drug abuse and sex education folders of resource materials proved the most timely and most popular.

Mental health programs and projects were adopted throughout Pennsylvania. Speakers and programs employing the participation of youth gained state-wide popularity. Three counties presented the skit, "Lady on the Rocks," in cooperation with the Council on Alcoholism. Volunteer effort is evident in hospitals through the maintenance of clothing shops, office help, gifts, and monetary contributions. One group presents service awards to outstanding nurses' aides.

In cooperation with organized groups and safety councils, committees assisted with hospital drills and personnel training. Boys and girls have become better baby sitters because of the GEMS Course (Good

Emergency Mother Substitutes.) The Block Mother Plan is popular. Resusci Anne, a water safety doll, purchased by a medical society and through demonstrations given several times a week by its auxiliary members, is deserving of mention.

International health activity was noticeable by one county helping to finance a Korean War orphan. Kyoung Sook Suk, whom we helped sponsor last year, has returned to Seoul. With our contributions, she is now working for her degree and helping to start a library for the blind. A tape recorder was donated to her by a county auxiliary. Other IHA activity included the distribution of community orientation kits to migrant workers and to Indians on reservations. Aid was given to Biafra, Project Hope, and Medico. Many auxiliaries collected and shipped approximately 14,000 pounds of hospital supplies. Knitted bandages were given to registered agencies.

The members received current medical legislative information. Membership in AMPAC and PaMPAC has been stressed. Several members serve on the PaMPAC Board. The importance of Auxiliary members and physicians writing "Letters to Legislators" was emphasized. Thirteen counties have communication contact systems established for the purpose of writing letters when requested by the Pennsylvania Medical Society.

Many of our counties have active, interested health career communities. In some areas, grant programs offer opportunities for young people to observe and actively participate in health-related work. This also proves valuable in helping to relieve the shortage of health-oriented personnel. "Meet Medicine" kits, prepared by the Pennsylvania Medical Society, were distributed to each organized auxiliary in Pennsylvania. Perhaps, in this area, more than any other, we might strive to become more active and secure more effective results. Special note must be given to the computor program which was initiated in a county. The medical society and a county foundation along with one of our members now serving on the Committee for Careers in Human Services, developed a program of career choice. Cards are made from questionnaires completed by seventh-grade students. Those indicating an interest toward a health career will be rechecked through junior and senior high school. These students are encouraged by adults who are pursuing careers which are closely related to the students' interests. The results of this project should prove interesting.

Home-centered health care increases as the awareness for the need becomes more obvious. Cooperation with existing agencies, churches, and hospitals seems to be a realistic approach. Several county auxiliaries provide meal service for its own members when necessary.

The liaison to the Woman's Auxiliary to the Student American Medical Association reported five WA/SAMA and five interns and residents wives chapters in Pennsylvania. Guest cards are given to each member should she decide to become more closely allied with the local medical auxiliary.

Doctors' Day is widely observed by gifts to libraries, medical exhibits, and social affairs to honor the physicians.

In addition to the contribution of $7,757.03 to the American Medical Association Education and Research Foundation, a sum of $6,845.75 was donated to the Pennsylvania Medical Benevolence Fund and $3,379.00 to the Educational Fund of the Educational and Scientific Trust of the Pennsylvania Medical Society.

We have continued to be aware of our responsibility to the children and youth of the Commonwealth. The board approved a Committee on Children and Youth. The 1970 White House Conference on Youth received a report of Auxiliary activity in this area as well as committee representation. The volunteer effort given to Head Start and Day Care Center programs is deserving of special mention. One county initiated and supports a pre-school class called "Boost." Other demonstrations of involvement included chauffeuring, providing clothing and a mitten tree, serving breakfast and lunch, and teaching good nutritional and health habits to the children and to the parents.

Because of the interest in education, tutorial time is given to unwed mothers as well as regular day students in need of special help.

The anti-violence campaign information appeared in the official newsletter, KEYSTONE NEWS.

The Annual Mid-Year Conference was well attended with representation from thirty-eight counties. The meeting provides an excellent opportunity for members to learn about programs and exchange ideas.

We appreciated the invitation to attend the meetings of the Pennsylvania Medical Society Councils on Public Service, Governmental Relations, and Education and Science. The Auxiliary president and president-elect attended the Officers' Conference of the Pennsylvania Medical Society. These meetings have proved invaluable as a source of information.

It is at the Council on Public Service meetings that the opportunity is afforded to meet with representatives of the Pennsylvania Association of Medical Assistants. It was inspiring to attend the state convention of this dedicated group of young women.

The Auxiliary has representation on the Pennsylvania Health Council, Community Services of Pennsylvania, and the Pennsylvania Society for Advancing Medical Research.

In closing, I wish to express my appreciation for the honor of having served as President of the Woman's Auxiliary to the Pennsylvania Medical Society. My sincere gratitude is extended to the state and county officers and chairmen and to each member of the Auxiliary whose support and cooperation made the duties of my office a joy to perform. To serve with such self-sacrificing individuals as George E. Farrar, Jr., M.D., president of the Pennsylvania Medical Society; the members of the Pennsylvania Medical Society; the Advisory Committee; Arlene C. Oyler, executive secretary of the Woman's Auxiliary to the Pennsylvania Medical Society; and the entire Pennsylvania Medical Society staff has been a lesson in charity and human brotherhood.

Public awareness of the general health of all peoples has made us more cognizant of the need for cooperation, not only with the members of the medical profession, but to give of ourselves to others by cooperating more fully with existing community agencies both as an individual and as a group. When we pause to reflect on the progress that has been made during 1968-69 and try to analyze the reasons behind it, we come inevitably

to one major underlying factor—service to our communities.

APPENDIX C

Remarks of the Vice President, SAMA Region III

MR. PETER L. ANDRUS

University of Pennsylvania
School of Medicine

At this point in the evening it's really with some trepidation that I approach the idea of addressing your group. Since it has been a long time, I would suggest that we start on a rather unorthodox basis and that would be that we stand up and stretch. It gives me great pleasure to be with you this evening. In view of the hour I will try to keep my remarks brief. However, there are a number of things I think we, myself as a student, you as practicing physicians, should be talking about. I don't think we are really going to have time to do all of that this evening but I would like to give you some perceptions I have about what is going on, let us say, in medical schools today and within our nation as a whole today, and I hope there may be at least a few points of perceptivity contained within.

The unrest that we are experiencing on our campuses today and the activism and militancy of students usually trigger reactions of surprise, shock and fear on a large part of the so-called backbone of our nation, the middle aged, middle class wage earners and professionals who represent in the eyes of many students the establishment. It is unfortunate that this reaction permeates such a large segment of our society. I think this reaction of the students in many cases is very much unwarranted. The actions of a generally small number of really radical students are not representative of the genuine deeply felt concerns of the larger numbers who would seek responsible change through more conventional means. My purpose this evening is neither to defend nor denounce either of these two approaches. I would not at this point draw unethical judgments about either approach. Instead, I would like to discuss with you briefly some of the sources of medical student activism which are growing today before I consider some of the forms that this activism has taken in translating theory into action.

Initially, I think it is pertinent to point out that the undergraduate demonstrator of two or three years ago is the first- or second year medical student of today. The first wave of activists in medical schools is really a recently arrived acquisition. The first year student may either commit himself to patient advocacy programs and curricular reform, while for the most part, battle-worn and seasoned veterans of the medical school wards, like myself, are more content to concentrate on our ward duties, wives, or our plans for an internship. We have in the fourth year in essence become a part of the establishment. We have been co-opted. Whether this is the inevitable result of our present means of dispensing medical education, or whether today's first- and second-year activists will be able to retain their present attitudes and vigor as they move into and through the clinical years I think is a hypothesis which remains to be tested.

A major influence upon today's student is, of course, that he is a part of and within the current system of health care delivery. Gross inequities are on full display to him; such as, the inadvertent waste and inefficiency in the use of facilities, funds and personnel; the blatant racial double standards; and economic double standards in health care. All these profoundly influence the student to reevaluate his own philosophy, his commitments, his priorities, and may even force him to develop a new social awareness and concern. A further influence for redirecting the student's interest toward social concern is that of his own personal frustrations. It's a frustration which I am sure many of you, if not all of you, knew when you were in medical school. Perhaps a manifestation of it in today's current scene is somewhat different.

Our current system of medical education in which clinical experience is largely delayed until the third year of study is to my mind wasteful of the stock of humanitarian impulses with which most people who enter medical schol come equipped. Thus, a seemingly endless postponement of this gratification of humanitarian drives results in frustration and discontent with the system. I think perhaps one of the healthiest signs in medical education today is a growing tendency for medical curriculum reform to lead toward earlier clinical experience for students. I think it's fair to say that a considerable amount of the drive and impetus behind this effort has been spurred by student activism.

After this somewhat lengthy preface, I would like to describe to you two or three different ways in which students are currently showing their concern for responsible student activism. These center around, I think, three distinct areas of concern. The first would be direct health care delivery. The second would be the economic administration and organizational aspects of our national health endeavor. And finally the politics of medicine. Well, what about student involvement in direct health care delivery? Close to home we see the example at the University of Pennsylvania of students participating in a neighborhood health survey history and physical program that is being conducted in the slum area known as Mantua just to the north of the University of Pennsylvania campus.

The students at Woman's Medical College are working on a sex education program that is coordinated with secondary schools in North Philadelphia. The Student American Medical Association on a national basis sought a grant at the beginning of this last summer for a program which would place 100 medical students and 20 nursing students in rural Appalachia for an eight-week period during the summer. This program provided students with the opportunity to see a number of different rural health care delivery settings and these students saw both general and specialty practice in both solo and group settings, and they worked with public health nurses and visiting nurses associations, with OEO programs, with migrant programs and with other governmental agencies. Throughout the summer work period, small groups of these students from Alabama to Pennsylvania met in order to exchange experiences and viewpoints on their work. Following the work-period of eight weeks, a two-day debriefing and evaluation session of the project was

conducted in order to assess the changes that occurred in student attitudes and perceptions regarding rural health care over the course of the summer.

Students are also concerned about the organization and financing of experimental systems of health care delivery. For example, the Institute for the Study of Health and Society, an organization which was last year created by students and operated by a student board of trustees, carried on a program for fifty medical students for eight weeks in Washington this summer. This program consisted of a two-week initial session of didactic presentations and seminars dealing with financial, organizational and administrative aspects of current health care delivery systems, as well as possible directions of future change. This period was followed by a four-week work session in which each student was assigned to some organizational component, either public or private, of the health endeavor in which he observed and reacted to its functioning. And finally the program was summed up in a debriefing period in which the relationship of various components of our health care organization were considered and evaluated by the participants. I think a major goal of this program is to produce a number of physicians who in the future will have the opportunity to think through the enormous and complex organizational problem which we, both as a nation and as the medical profession, must face. I think we will produce thereby health professionals who will be sensitive to the tremendously complex problems which do face us in restructuring and improving the system through which we are able to provide health care to all the people of this nation.

Students are also involved locally in work of the ad hoc committee, an organization which has been set up to increase the number of black and other minority group students who are being admitted to medical schools. Many of you who are from either the Philadelphia area or the immediate environs may recall the CBA, the Committee for Black Admissions, which functioned last year. This committee was so successful that at the present time there are over fifty black students, who are enrolled in the first-year classes of the five medical schools here in Philadelphia. I think this compares rather favorably with the number I have heard quoted of twenty-six, the total number which were enrolled in all four classes of these five schools during the immediate previous year.

Finally, students are engaging in direct effort to influence the politics of medicine. At present, for example, Congress has under consideration, as has been alluded to earlier this evening, a proposal which would reduce financial assistance to health profession students by about 40 per cent in the coming year. Representatives of the Student American Medical Association have carried the message to representatives and senators in Congress through testimony before the House Appropriations Committee, through a massive student letter-writing campaign and through personal interviews. We intend to carry further our efforts in this area and will be testifying before the Senate Appropriations Committee later this fall. I might add, too, parenthetically at this point, that when the presidents of the fifty state medical societies were requested to provide support for SAMA activities in this particular regard, the President of the Pennsylvania Medical Society was the first to respond.

I am going to try to close rather quickly because I know we're running short on time. I would just like to pose the following question: What is the relationship of student activism and students in general to the Pennsylvania Medical Society or to organized medicine? I think the very fact that you were able to get a half dozen students who came and joined you for this meeting this evening, I think this in itself is significant. I probably would get labeled by a number of my classmates as being a "wild-eyed radical" and an equal number would probably label me as being very much a conservative. There is a wide range of student viewpoints just as there is a wide range of practicing physician viewpoints represented within this organization and within the medical schools today. Well, what's the point of all this, then? It would be my basic contention that it's very easy for students on the outside to look at organized medicine, such as the AMA or PMS, with a great deal of suspicion. You are the establishment. You are concerned only about making money. You are interested only in solo practice, fee for service—it's the stereotype that we all get fed. You, on the other hand, might be likely to view students as long-haired, unshaven, unkempt, unbathed—indeed perhaps it's a surprise that I didn't come in here and spout a beard and, look like a complete grub. Surprise! Neither of these stereotypes is correct. Both images miss the point and I think the point is this. We have a unique opportunity to communicate, to share views, to develop understanding and sensitivity to each other's points of view and ideas. There's no guarantee that I'm going to buy everything you try to tell me and I'm pretty sure you're not going to buy everything I try to tell you, but I would strongly urge that all efforts that this society and organized medicine can make and all efforts that students can make to come together and to share in a dynamic interaction be pursued.

I would suggest that one of the most immediate ways in which this House of Delegates and this convention can act is to consider positively the resolution which has been presented in the report of your President this evening and consider with it the report of your Committee on Constitution and Bylaws relating to voting student representation in your House of Delegates. I think that further discussion of this should be left to the reference committee and to the floor of the House of Delegates. I look forward to an active and interesting interchange on this issue and on a number of other issues which will come before your House within the next few days. I thank you very much for your courtesy in listening to me this evening.

APPENDIX D

Supplemental Report
Council on Medical Service

To: The House of Delegates

Resolution 68-12 (Availability of Medical Care)

In adopting Resolution 68-12, the 1968 House of Delegates of the Pennsylvania Medical Society recommended that a program be developed to assure high quality medical care for all citizens of Pennsylvania.

This resolution (Appendix D1) was referred to the Council on Medical Service for implementation. As indicated in the Council's annual report to the House, it was not clear whether the intent was to re-state a basic objective of the Society or whether its sponsors had a specific program in mind to achieve this objective. As a result of correspondence with the author of the resolution, the Council learned that his intent was to have the Pennsylvania Medical Society sponsor the development of medical centers in poor urban areas to be financed through voluntary contributions, Pennsycare payments, OEO funds, and possibly through the donation of monies via the members of the Pennsylvania Medical Society. In addition, it was suggested that medical instruments, drugs, and other medical supplies, might be obtained through donations from drug companies.

It is the feeling of the Council, that from a practical point of view, the Pennsylvania Medical Society and its component county medical societies cannot undertake the development of medical centers of various types, but can give encouragement and support in various ways to new projects such as, for example, in the past year, a multiphasic screening program in Philadelphia, a diagnostic virus and mycoplasma laboratory in Philadelphia, Gateway Medical Center in Pittsburgh, and a medical student preceptorship program under Appalachia. Individual physicians and county medical societies should be encouraged to exert leadership.

However, the Council agreed that the Pennsylvania Medical Society should continue to call attention to factors which appear to interfere with the availability and delivery of quality medical care and should participate in efforts to improve problems in the financing and delivery of health care. Because of the influence of several factors over the past three or four years there has been a significant increase in demand for medical services which has further accented the inequity in the distribution of health care resources at a time when the government and the public have expressed widespread concern about this apparent lack of equity and the cost of health care continues to rise. Of particular concern is the assumption that many citizens of Pennsylvania with inadequate income, for a variety of reasons, either do not obtain needed medical care at all or obtain it under conditions that are below the standard of care utilized by the general population. An additional concern are those who could afford to pay for medical and hospital care on a prepayment or insurance basis, but who either elect not to do so or are not eligible for effective coverage. Such situations create serious personal financial problems for the patient's family and when people in this category become seriously ill, the public must share the financial burden, since those who have prepayment or insurance plans must pay both higher premiums and higher taxes to subsidize the uninsured.

The Council believes that Resolution 68-12 was designed to aid the former group in meeting their health care needs as well as upgrading the care available to those able to afford it, and we suggest that the Pennsylvania Medical Society pursue the following alternatives as a means of achieving the basic objective of the resolution.

The Pennsylvania Medical Society should:

1. Reaffirm its desire to support projects whose objectives are to improve the financing and delivery of health care organized in such a way as to develop or strengthen a first class system of health care which will embrace the principles of medical ethics of the American Medical Association.
2. Support a mechanism or system for financing health care that does not limit or restrict the methods of providing health services or interfere with the choice of providers in order to preserve the desired freedom of choice for both patients and physicians.
3. Urge that, to the extent possible, the system or plan should utilize existing financial mechanisms—Blue Shield, Blue Cross, insurance companies, group practice plans, and other voluntary programs.
4. Urge payment for physicians' services, regardless of where they are provided, to be determined by application of the usual, customary, and reasonable fee concept.
5. Support the development of an adequate Pennsycare Program, in accordance with past action of the Pennsylvania Medical Society, appropriately financed with a greater share of federal funds for all covered services as an interim step toward organizing a better system of health care.
6. Support the concept of allowing Social Security beneficiaries a choice of fiscal intermediaries giving them a greater flexibility to experiment in the design of benefits to improve service, benefits, and conserve health manpower to avoid further diversion of health care personnel to administrative work, which both inflates the unit cost of service and diminishes the manpower available for patient care.
7. Support the graduated income tax credit program proposed by the American Medical Association to strengthen the voluntary health insurance industry and to reduce the need for governmental health programs.
8. Support legislation at both the state and federal levels that would make available to all employed persons and their dependents a voluntary non-governmental prepayment or insurance health care plan of maximum flexibility but with benefits no less than the minimal Blue Cross-Blue Shield Programs.
9. Support legislation that would provide greater incentives for medical schools to increase enrollment.

The Council fully realizes that these nine recommendations must be considered long-range objectives, but their implementation in the end may very well achieve the goal of developing and financing programs to assure high quality care for all citizens of Pennsylvania. Moreover, there has been much discussion regarding universal compulsory coverage and such a program should render obsolete the need for a national governmental compulsory health insurance by assuring a comprehensive health plan for everyone.

Based on these guidelines, this system of financing offers a number of advantages:

1. A minimum burden is placed on the federal government since its further financial commitment would involve only the subsidization of premiums for those individuals and families unable to afford the premium for coverage.
2. It would preserve a large role for decentralized decision making which is important for the stimulation of individual effort and for the opportunity to experiment with alternative approaches.
3. The system preserves the desired freedom of choice for both patients and physicians.
4. The system permits the patient to purchase more than the basic coverage which is consistent with the general free approach to consumer spending and this would likely encourage the upward movement of quality which tends to suffer when there is an attempt to freeze everyone into a single standard.

The Council believes that organized medicine has a vested interest to assist more aggressively in speeding the development of the voluntary health insurance programs as major components in the preservation of the private financing of health services and, therefore, the Council recommends that the medical profession take the leadership in the refinement and development of the general guidelines included in this report as both an alternative to national compulsory health insurance and as a means of implementing Resolution 68-12.

MALPRACTICE INSURANCE

As indicated in the Council's annual report to the House of Delegates, the most recent developments in the area of malpractice insurance are included in the following report.

Group Malpractice Insurance Program

The Council has received responses from all sixteen of the insurance companies or insurance brokers contacted in efforts to organize a State Society group program. Fifteen of the companies indicated they were not interested in expanding their present exposure in the malpractice line and the one remaining company has quoted rates for a State Society Program which are not very realistic but, nevertheless, the Council intends to pursue the possibilities of establishing a group program with this company and plans to contact any other interested company or any of those already contacted who may reconsider their position.

Reciprocal Company

The Council reviewed proposals from two agencies to organize a reciprocal company for the members of the Pennsylvania Medical Society. The Council agreed that this would be a major undertaking and, in view of the present developments, action should be postponed with the understanding that this approach should not be overlooked as a future possibility. In reaching this conclusion, the subcommittee took into consideration the problems encountered by Empire Casualty Company, a reciprocal firm organized by physicians in Colorado, which was recently forced to sell out to a large casualty carrier because of inadequate capitalization. The report of the comprehensive study conducted by the California Medical Association pointed out several serious drawbacks to such an approach and concluded that any company, whether physician owned or administered, will do little to remove the real causes of the malpractice insurance problems.

Medical Accident or Maloccurrence Insurance

The Council reviewed an account prepared by the AMA regarding medical accident insurance for patients. This concept is similar to that employed by insurance companies whereby airline passengers may purchase an accidental death and dismemberment policy for any given flight. The subcommittee felt such a concept deserved further study and will follow the activities of the AMA in this area.

Physician Responsibility

Finally, in accordance with the AMA principle of medical ethics which states as follows: "The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence." The Council agreed that the Pennsylvania Medical Society should make it abundantly clear to the public and any others outside the medical profession that physicians are looking for ways to better safeguard the public and agreed that a patient is entitled to a reasonable recovery for personal injury that is a result of a negligent act.

(APPENDIX D1)

Resolution 68-12: Availability of Medical Care

(As adopted by House of Delegates of Pennsylvania Medical Society, September 29, 1968)

WHEREAS, The availability of medical care may be unequal in all areas of Pennsylvania; and

WHEREAS, Organized medicine has taken no major action in assuring the availability of good quality medical care to all Pennsylvania citizens, and

WHEREAS, Government agencies are planning government or institution-based programs to assure good medical care to all citizens; therefore be it

Resolved, That the Pennsylvania Medical Society authorize and direct the appropriate Council of the Society to formulate a plan whereby organized medicine may assure the availability of quality medical care for all citizens of Pennsylvania.

APPENDIX E

PaMPAC 1969 Report to the House of Delegates

Mr. Speaker, Mr. President, Mr. President-Elect, Members of the House, distinguished guests—As chairman of the Pennsylvania Medical Political Action Committee, I appreciate this opportunity to be able to report about the political arm of our medical society.

Four years ago, I addressed the House of Delegates as President of the Pennsylvania Medical Society. At that time, I had emphasized that we could not let our profession stand in the way of our being complete citizens. I had mentioned that we can-

not combat political pressures by only being an excellent physician. Ladies and gentlemen, today, our profession is more committed to the political pressures in our society than in any other period of history. Essentially, this country is faced with a most rapid and radical change—some people call it a revolution. This change is not only limited, of course, to health care or medicine, but this area becomes rather gray when these demands filter through the mass of people and reach the elected state and federal officials. However, the basic necessity remains clear in the health field, and we can say that medicine is presented with an insoluble problem since the mandate calls for almost instant organizational changes in our methods of caring for people. How do we deal with this demand—not only as citizens, but as members of a profession responsible for the nation's health?

Government, indeed, is involved with health activities because it is the duty of the government to be interested in all the needs of all the people—and to seek the best way, not necessarily to fill those needs, but more often to create a social, political and economic climate in which citizens themselves can find ways to fill them. For instance, in our own state last year, we saw the introduction of over 100 bills pertaining to health and on the national level, over 1,400 pieces of legislation directly or indirectly related to health care were introduced. Ladies and gentlemen, we are already in political action to meet this rapid expansion of state and federal activities in the areas of health and medicine. We cannot practice medicine in a world of our own. It is the obligation to our profession and as citizens to help government meet these needs and solve the problems pertaining to the health care of physicians. Legislation is passed by the elected officials and not the physicians and, therefore, it is our responsibility to see that we elect and support the right person.

In his presentation at the AMPAC Workshop in Washington this year, Dr. Wilbur, immediate past president of the AMA, stated: "Neither politics nor government respond to solo effort in a democratic society. They respond to majorities. So if we are to do much about the course the country takes, or about the people running it, we must join forces with others of like mind. There is no other way to make our voices heard or make our participation felt."

We should remember that in education and political action, our arm is PaMPAC. Essentially, PaMPAC is devoted to supporting candidates who acknowledge medicine's legislative goals. Political actions effectiveness is in direct proportion to the support of its members. I hope that the physicians of Pennsylvania were pleased with our accomplishments that were made over this past year. Since our last report before the House, PaMPAC was involved in supporting candidates in the 1968 congressional and state legislative elections. Seventy-seven percent of those candidates supported by PaMPAC were elected, and many of them on the state and federal level have been placed on key committees that are responsible for dealing with matters of vital interest to medicine. Let me make this point clear—we are interested in the candidates' philosophies concerning medicine—not his party affiliation. Every year, all the various polls—the Harris, the Gallup, etc., have indicated that more people are registering independent and, therefore, the trend is not to vote for the party but to vote for the person. We must remember that we are interested in the man or woman who will support medicine's viewpoints.

Political education is definitely an important factor in our profession today. In March 1968, PaMPAC held its first political action workshop on a statewide basis. This workshop was directed toward instruction in basic political action with emphasis upon the role that the medical community can perform at the grass roots level. I believe the outcome of this workshop speaks for itself when looking at the time, work and hard cash that was put into the 1968 campaign from the grass roots level.

PaMPAC implemented the first medico-political scholarship program to encourage first year students of the seven medical schools in Pennsylvania to illustrate a knowledge of appreciation for medical practice within the framework of a free enterprise society. Seven medical students were awarded $500 scholarships based upon an essay on the topic, "The Physician's Role As A Citizen".

An increasing number of physicians and their wives played vital roles on the grass roots level giving their time and talent to the effort of getting their candidate elected in the 1968 election. Approximately 33 percent of the physicians belonging to the Pennsylvania Medical Society made financial contributions to PaMPAC in 1968. Consequently, PaMPAC was second in the national ranking of state PACS with respect to total funds raised.

All of these accomplishments go to the individual physician who through his contribution in dollars and through his involvement in practical politics has made an impact in making the voice of medicine a greater factor in representative government.

1970 will, indeed, be a challenging year for the Pennsylvania Medical Political Action Committee. In view of some startling upsets in 1969 off-year elections, some surprises may be in store for either or both of the two major parties. In the State of Pennsylvania, we will be electing a governor and a United States senator. Some of the congressional districts in Pennsylvania will be under consideration for redistricting which will definitely affect some of the influential races in the United States House of Representatives.

This past year of reflection and experience has definitely set the pace for our political arm in 1970. The responsibility of the Society's legislative machinery will be in full operation. Therefore, we need that person in government who will carry medicine's philosophies.

To quote Dr. Wilbur, "The physician who remains aloof from politics forfeits the greatest opportunity of citizenship—his say in determining who in government will represent him. And, the physician who is indifferent to government is indifferent to the very force that can shackle his profession and otherwise diminish the standard of health care he can render his patients".

In a letter that was recently sent to me by Dr. George Farrar as president of the Pennsylvania Medical Society, he stated, "Our splintering into specialty societies has improved the qual-

ity of health care but weakened our voice in our civilization. We must join ranks in order to solve the health problems of our citizens—all our citizens—before our great profession is destroyed and we find ourselves technicians of disease. Apathy of the membership is discouraging to the 'front men' of all human organizations."

I strongly urge all members of the Pennsylvania Medical Society to support PaMPAC with membership dollars and acitvities. With sufficient support, we then can reap the benefits in health care. With our knowledge, skill, and creative abilities, I hope we can work cooperatively in politics through the coming years, so we can achieve our goal of preserving the high quality of medical care.

I can think of no better way to end this report than to recognize one of the pioneers who started this organized political action. The foundation for PaMPAC's success was laid by men with foresight and resoluteness. Thus, the PaMPAC Board has unanimously agreed to the presentation of this honorary life membership in PaMPAC. The recipient of this award was one of the original five men who started political action in Pennsylvania. For a period of time, he served as chairman on legislation.

At this time, I want to call Dr. Stephen J. Deichelmann forward.

Ladies and Gentlemen, I hope you will join the PaMPAC board in this expression of appreciation to Dr. Deichelmann for a difficult job well done.

APPENDIX F

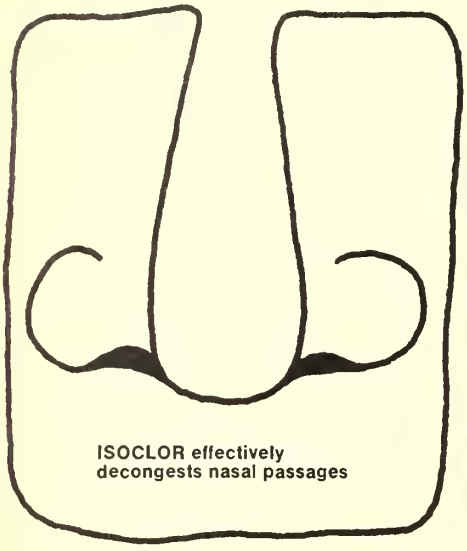
Telegram from

Mr. Marvin Comisky, president-elect, Pennsylvania Bar Association

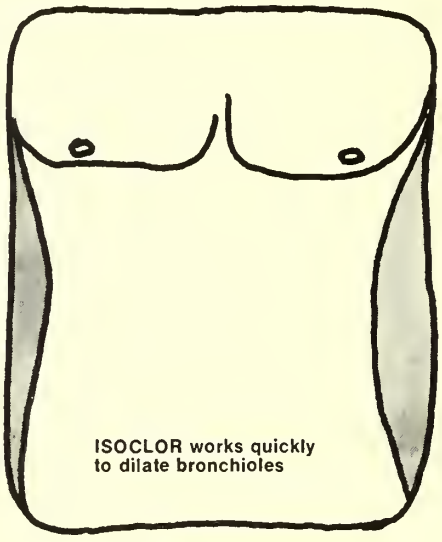
Dr. George E. Farrar
Marriott Motor Hotel
Philadelphia

Regret that illness prevents the attendance of Mrs. Comisky and myself. We do look forward to a raincheck hopefully on the occasion of your next meeting. Please accept our thanks for the invitation and express our regrets also to Dr. and Mrs. William Alexander who graciously agreed to be our host.

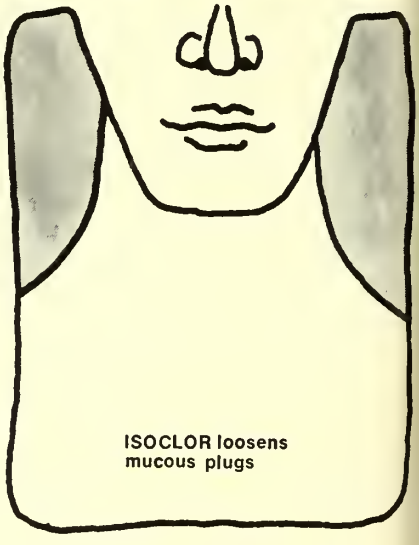
HERE ARE THE COLD FACTS:



ISOCLOR effectively decongests nasal passages

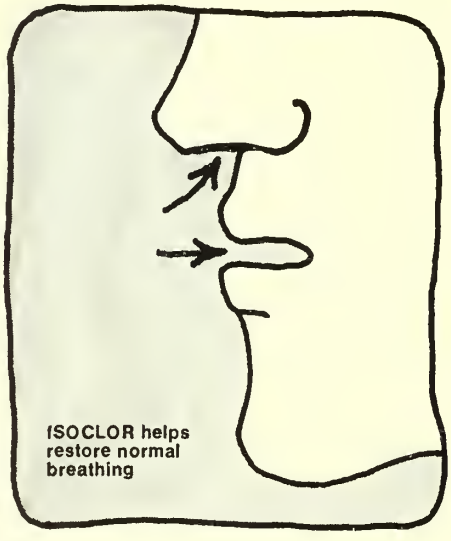


ISOCLOR works quickly to dilate bronchioles



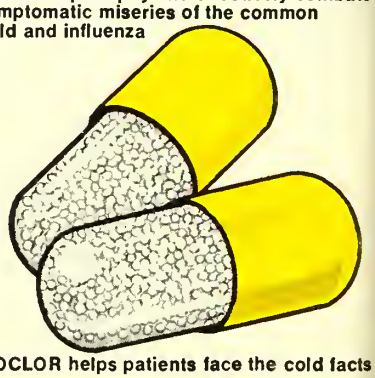
ISOCLOR loosens mucous plugs

ISOCLOR relieves runny eyes



ISOCLOR helps restore normal breathing

ISOCLOR promptly and effectively combats symptomatic miseries of the common cold and influenza



ISOCLOR helps patients face the cold facts

ISOCLOR®

Isoclor provides quick, long lasting relief of respiratory congestion and discomfort brought on by common colds, influenza, and allergies. Isoclor contains chlorpheniramine maleate — one of the most potent and safest antihistamines. And pseudoephedrine HCl — a decongestant bronchodilator providing effective and long lasting relief for the entire respiratory tract. Both work to extend the range of relief.

COMPOSITION: Each tablet or 2 teaspoonfuls of liquid contains:
Chlorpheniramine Maleate.....4 mg.
Pseudoephedrine HCl.....25 mg.

Each ISOCLOR Timesule contains:

Chlorpheniramine Maleate.....10 mg.
Pseudoephedrine HCl.....65 mg.
In a special pellet form providing both prompt and sustained effect.

INDICATIONS: For symptomatic relief of colds, hay fever, allergic conjunctivitis, perennial rhinitis of allergic origin and sinusitis. Opens nasal, sinus and bronchial passages orally.

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

PRECAUTIONS: Use with caution in patients suffering with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Tablets: Bottles of 100 and 1000. Liquid: 4 oz. bottles, pints, and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

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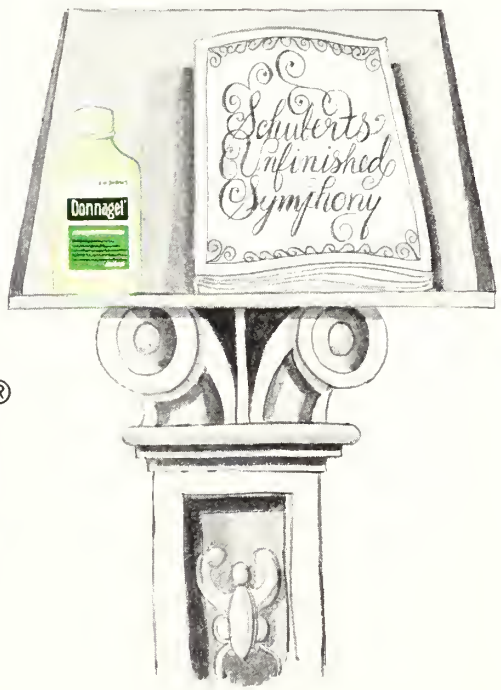
The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can ri e at the most inopportune time, it takes a comprehensive agent to treat the ota diarrheal syndrome and help get the patient back on the job. That's why p any physicians rely on Donnagel, especially during the fall and winter no hs when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination. t so contains the belladonna alkaloids to calm GI hypermotility and help eli e the distressing discomforts which so often accompany diarrhea. Certainly t's ess expensive and more convenient than taking two medications. And the os e is lower too. Available in the handy 4-oz. plastic bottle at pharmacies ve where on your prescription or recommendation.



For Diarrhea and its Discomforts

Donnagel®

Eac fluid ounce contains: Kaolin, 6 Gm.; Pectin, 142.8 mg.; Hyoscyamine sulfate, 0.1 7 mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.; odium benzoate (preservative), 60 mg.; Alcohol, 3.8%.

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Robitussin
Robitussin-DM
Robitussin A-C
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4 FL OZ.
Robitussin-DM
Cough Calmers
Cough Calmers
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CLEAR THE TRACT!

THERE'S A ROBITUSSIN FOR EVERY COUGHING NEED

All the Robitussins contain gylceryl guaiacolate, an outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control
ROBITUSSIN-DM®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Dextromethorphan hydrobromide . . . . 15.0 mg.
Alcohol, 1.4%

For unproductive allergic coughs
ROBITUSSIN A-C®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Phenylephrine hydrochloride. . . 10.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"
COUGH CALMERS™
Each Cough Calmer contains:
Glyceryl guaiacolate . . 50.0 mg.
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Use this handy guide to pick the right formulation for each coughing need

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Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●		●
Antihistamine			●		
Long-Acting (6-8 hours)		●			●
Nasal, Sinus Decongestant				●	
Non-narcotic	●	●		●	●

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continuing education

A list of educational opportunities offered to physicians in the interest of maintaining their competence and skill. Unless otherwise indicated, all courses are designed for physicians engaged in primary patient care.

ADOLESCENTS' MEDICAL CARE

February 26, 1970; York Hospital

1/AMA—**Occurrence and Genesis of Abnormal Menstruation at Puberty** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

ANESTHESIOLOGY

March 7, 1970; Cherry Hill Inn (N. J.)

C/S—**11th Annual Postgraduate Anesthesia Seminar;** by N. J. State Soc. of Anesthesiologists; $4 fee ($14 for nonmembers of NJSSA). Contact Bertram H. Shapiro, M.D., NJSSA, 180 E. 21st St., Paterson, N.J. 07513.

ARTHRITIS AND RHEUMATISM

February 11, 1970; Philadelphia

C/AMA—**Rheumatoid Arthritis;** at Albert Einstein Med. Center; 6 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chrm., Albert Einstein Med. Center, York & Tabor Rds., Philadelphia 19141.

CARDIOVASCULAR DISEASE

December 9, 1969; Chester

I/AMA—**Clinical Applications of Cardiac Catherization** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 17, 1969; Scranton

I/AMA—**Pre and Postoperative Problems in the Patient Subjected to Cardiac Surgery** (Program of Continuing Medical Education—3rd Wed. ea. mo., 8 mos.); by Jefferson and Penn State at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Wilkes-Barre General Hospital

I/AMA—**Acute Stroke Syndrome** (Program of Continuing Medical Education—One Thursday Each Month); by Jefferson & Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Associate Dean, Jefferson, 1025 Walnut St., Phila. 19107.

"CODE KEY"

C—Consecutive days
I—Intermittent
O—Circuit
PG—Postgraduate Traineeship
R—Radio
TV—Television
S—Designed for full-time specialists
AMA—AMA Accredited Institution

C E S—Council on Education and Science, Pennsylvania Medical Society
Hahnemann—Hahnemann Medical College and Hospital
Hershey—Milton S. Hershey Medical Center
Jefferson—Jefferson Medical College of Philadelphia
Penn-Grad—University of Pennsylvania, Division of Graduate Medicine
Pitt—University of Pittsburgh School of Medicine
Pitt P.H.—University of Pittsburgh Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania School of Medicine
Woman's—Woman's Medical College of Pennsylvania

January 7, 1970; Allentown

I/AMA—**How to Avoid Code Blues? (Cardio Respiratory Collapse);** (8 weeks Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP Credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

January 8, 1970; Allentown Hospital

I/AMA—**Heart Sounds** (Program of Continuing Medical Education, 2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 22, 1970; Pottsville

I/AMA—**Intractable Congestive Heart Failure** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

January 27, 1970; Chester

I/AMA—**Anticoagulants in Cardiovascular Disorders** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; York Hospital

I/AMA—**New Concepts in Cardiac Surgery** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

March 4, 1970; Allentown

I/AMA—**Integrated Management of the Patient with Cardiogenic Shock** (8 week Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp.; Allentown 18102.

March 18, 1970; Reading

I/AMA—**The Management of the Hypertensive Patient Undergoing General Surgery** (Continuing Education Program—3rd Wed., 8 months); by Hahnemann at Community General Hosp. Contact Paul K. Stolz, M.D., Dir., Continuing Educa., Community Gen. Hosp., 135 N. 6th St., Reading 19601.

March 19, 1970; Williamsport Hospital

I/AMA—**Coronary Artery Disease; Pre-Infarction and Post-Infarction. Problems of Recognition and Management** (Postgraduate Seminars held 3rd Thurs. ea. mo.); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 21, 1970; Wilkes-Barre General Hospital

I/AMA—**Drugs and the Heart** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

CHEST DISEASES

January 21, 1970; Reading

I/AMA—**Respiratory Failure** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Community General Hosp. Contact Paul K. Stolz, M.D., Dir. Cont. Educa., Community Gen. Hosp., 135 N. 6th St., Reading 19601.

January 21, 1970; Scranton

I/AMA—**Pre and Postoperative Problems in the Patient with Pulmouary Disease** (Program of Continuing Medical Education—3rd Wed. ea. mo.; 8 mos.); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 4—March 25, 1970; Philadelphia

I/AMA—**Diagnosis and Management of Chronic Respiratory Disease** (Each Tuesday—8 weeks); at Albert Einstein Medical Center; 20 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

February 9-20, 1970; Philadelphia (Repeat April 6-17, 1970)

PG/AMA—**Postgraduate Course in Bronchoesophagology;** at Temple; for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. $350 fee. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

March 17, 1970; Chester

I/AMA—**Pulmonary Infiltrates: TB or Not TB?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 24, 1970; Chester

I/AMA—**The Use and Abuse of Oxygen Therapy** (Program of Continuing Medical Education Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 31, 1970; Chester

I/AMA—**The Solitary Pulmonary Nodule;** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 21, 1970; Pottsville

I/AMA—**Acute Respiratory Failure; Diagnosis & Management** (Cont. Education Program 3rd Wed., 8 mos.); by Hahnemann at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

DERMATOLOGY

April 16, 1970; York Hospital

I/AMA—**Dermatologic Drug Reactions and Their Pathophysiology** (Program of Continuing Medical Education —Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

ELECTROCARDIOGRAPHY

January 25 and February 1, 1970; Pittsburgh

I—**Electrography—Newer Concepts;** by Pitt. and West Penn and Shadyside Hosps.; at West Penn (1/25/70) and Shadyside (2/1/70); 5 hrs. AAGP credit, $15 fee (both Sundays). Contact John B. Hill, M.D., West Penn Hosp., 4800 Friendship Ave., Pittsburgh 15224.

February 25—April 29, 1970; Philadelphia

I/AMA—**Advanced Electrocardiography;** Each Tuesday, 10 weeks; at Albert Einstein Medical Center, 30 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

ENDOCRINOLOGY

January-May, 1970 (3rd Thurs. ea. mo.); Bethlehem

I—**Endocrinology: Medical and Surgical Aspects;** at St. Luke's Hosp., by Jefferson; 24 hrs. AAGP credit; $24 fee (6 seminars), $7 ea. Contact Michael L. Sheppeck, M.D., Med. Dir., St. Luke's Hosp., Bethlehem 18015.

January 15, 1970; Bethlehem;

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Pituitary Gland;** (Program of Continuing Medical Education); By Jefferson and Penn State at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

February 3, 1970; Chester

I/AMA—**The Problem Diabetic** (Program of Continuing Medical Education —Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 10, 1970; Chester

I/AMA—**Thyroid Function Tests—How to Evaluate Them** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D. M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 17, 1970; Chester

I/AMA—**Thyroid Nodule—When Not to Operate** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Thyroid Gland.** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital, 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia.

February 24, 1970; Chester

I/AMA—**The Outpatient Management of Anemia** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 1, 1970; Pittsburgh

C—**Diagnosis and Treatment of Endocrine Abnormalities in the Female;** by Pitt and West Penn and Shadyside Hosps.; at West Penn Hosp.; 5 hrs. AAGP credit; $15 fee. Contact John B. Hill, M.D., West Penn Hosp., 4800 Friendship Ave., Pittsburgh 15224.

March 4, 1970; Chester

I/AMA—**Enigma of Hypoglycemia** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Parathyroid Gland.** (Program of Continuing Medical Education) by Jefferson & Penn State at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Phila. 19107.

March 19, 1970; Pottsville

I/AMA—**Modern Treatment of Diabetes** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

March 22, 1970; Pittsburgh

C—**Diagnosis and Treatment of Endocrine Abnormalities in the Male;** by Pitt and West Penn and Shadyside Hosps.; at West Penn Hosp.; 5 hrs. AAGP credit; $15 fee. Contact John B. Hill, M.D., West Penn Hosp., 4800 Friendship Ave., Pittsburgh 15224.

March 26, 1970; York Hospital

I/AMA—**What's New in Endocrinol-**

ogy (Program of Continuing Medical Education—Each Thursday, 3 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 16, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Adrenal Gland** (Program of Continuing Medical Education) by Jefferson and Penn State; at St. Luke's Hospital, 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Phila. 19107.

April 16, 1970; Pottsville

I/AMA—**Treatment of Hyperthyroidism** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

April 28, 1970; Johnstown

I/AMA—**Obesity** (Program of Continuing Medical Education—Last Tuesday—7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 7, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Ovary** (Program for Continuing Medical Education); by Jefferson and Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 15, 1970; Scranton

I/AMA—**The Diabetic and Surgery** (Program of Continuing Medical Education—3rd Wed. ea. mo. 8 mos.); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 20, 1970; Reading

I/AMA—**Adrenal Disorders** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Community General Hosp. Contact Paul K. Stolz, M.D., Dir., Cont. Educa., Community General Hosp.; 135 N. 6th St., Reading 19601.

May 21, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Tumors of Nonendocrine Origin** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Phila. 19107.

GASTROENTEROLOGY

February 19, 1970; Williamsport Hospital

I/AMA—**Dilemmas of a Belly Ache** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 9, 1970; Allentown Hospital

I/AMA—**Ulcerative Colitis** (Program of Continuing Medical Education, 2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 14, 1970; Chester

I/AMA—**Inflammatory Diseases of the Bowel** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 15, 1970; Scranton

I/AMA—**Preparation of and Postoperative Care of the Patient Requiring Surgery of the Hepato-Biliary Tract** (Program of Continuing Medical Education—3rd Wed. ea. mo., 8 mos.); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 21, 1970; Chester

I/AMA—**The Irritable Colon Syndrome and Diverticular Disease of the Colon** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 29, 1970; Chester

I/AMA—**Immunoglobulins and the GI Tract** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

June 1, 1970; Philadelphia

I/AMA—**Chronic Hepatitis** (Program of Continuing Medical Education); by Jefferson and Penn State; at Methodist Hospital; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

GENERAL MEDICINE

Every Thursday; Hazleton State General Hospital

I—**Program of Continuing Medical Education by Hazleton Branch, Luzerne County Medical Society.** Contact Robert Gunderson, M.D., Suite 412 Northeastern Building, Hazleton, Pa. 18201.

December 4, 1969; Altoona Hospital

I/AMA—**Innocent Murmurs in Children;** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 4, 1969; Pottsville Hospital

I/AMA—**The Pill—More Than the Answer to a Maiden's Prayer** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 9-12, 1969; Philadelphia

C/AMA—**Emergencies in Medical Care;** by Hahnemann; at Marriott Motor Hotel; 56 hrs. AAGP credit applied for; $150 fee—paramedics $35. Contact Stanley Spitzer, M.D. or Wilbur W. Oaks, M.D., Hahnemann, 230 North Broad St., Philadelphia 19102.

December 12, 1969; Williamsport Hospital

I/AMA—**Current Concepts of Thyroid Disease** (Program of Continuing Medical Education 2nd Fri. each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 15, 1969; Johnstown

I/AMA—**Drug Reactions** (Program of Continuing Medical Education—3rd

Monday—7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Altoona Hospital

1/AMA—**Approach to the Patient with Fever of Unknown Origin** (Pro—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Bethlehem

1/AMA—**Immunologic Basis for Drug Reactions** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital, 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18-19, 1969; Erie

1/AMA—**Autoimmune Disease** (Program of Continuing Medical Education —twice a month, Sept.-Dec.); by Jefferson and Penn State; at St. Vincent Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

January 8, 1970; Pottsville Hospital

1/AMA—**Chronic Leg Ulcers** (Program of Continuing Medical Education —1st Thursday Each Month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

January 15, 1970; Altoona Hospital

1/AMA—**Newer Diagnostic Techniques in Radiology** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

February 3, 1970; Lebanon

1/AMA—**Adolescent Psychiatry** (Continuing Medical Education Program—1st Tues., 4 mos.); by Jefferson and Penn State; at Quentin Riding Academy; 2 hrs. AAGP credit; $8 fee ($35 for 4 sessions). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 5, 1970; Altoona Hospital

1/AMA—**Current Theories Concerning Causation of Cancer** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

February 5, 1970; Pottsville Hospital

1/AMA—**Hepatitis** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 3, 1970; Lebanon

1/AMA—**Use and Misuse of Anti-Biotics** (Continuing Medical Education Program—1st Tues., 4 mos.); by Jefferson and Penn State; at Quentin Riding Academy; 2 hrs. AAGP credit. $8 fee ($35 for 4 sessions). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 5—April 16, 1970; DuBois Hospital

1—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Alternate Wednesdays, 11 sessions); by C E S; 33 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

February 5, 1970; York Hospital

1/AMA—**What's New in Antibiotics and Cardiac Drugs** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 12, 1970; Allentown Hospital

1/AMA—**Early Diagnosis of the Stroke Prone Patient** (Program of Continuing Medical Education—2nd Thursday, each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 12, 1970; York Hospital

1/AMA—**Pathophysiology of Hepatic Failure** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 13, 1970; Williamsport Hospital

1/AMA—**Surgical Aspects of Venous and Arterial Insufficiency of the Lower Extremities** (Program of Continuing Medical Education—2nd Friday of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Altoona Hospital

1/AMA—**Hyperlipodemias** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Wilkes-Barre General Hospital

1/AMA—**Clinical Application of Scanning Techniques** (Program of Continuing Education—One Thursday each month); by Jefferson & Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

March 5, 1970; Altoona Hospital

1/AMA—**Management of The Pregnant Diabetic** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

March 5, 1970; Pottsville Hospital

1/AMA—**Infections of the Central Nervous System** (Program of Continuing Medical Education 1st. Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia.

March 12, 1970; Allentown Hospital

1/AMA—**State of Renal Transplants** (Program of Continuing Medical Education, 2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 13, 1970; Williamsport Hospital

1/AMA—**The Physician's Role in Sex Education** (Program of Continuing Medical Education 2nd Fri. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Altoona Hospital

1/AMA—**Aggressive Management of**

Patients with Stroke (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

April 1, 1970; Allentown

I/AMA—**Errors in Emergency Practice** (8 week Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

April 2, 1970; Altoona Hospital

I/AMA—**Emotional Problems at Adolescence** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

April 2, 1970; Pottsville Hospital

I/AMA—**Genetic Implications of Drugs and Radiation Exposure** (Program of Continuing Medical Education, 1st. Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 7, 1970; Chester

I/AMA—**Antibiotics—Uses and Abuses** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks; by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 16, 1970; Altoona Hospital

I/AMA—**Diagnosis of Anemia** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

May, 1970; Pitt

C—**Fourth Annual Symposium on Acute Medicine;** at Scaife Hall; 5 days; 40 hours AAGP credit applied for. Contact Sally Barr, Admin. Asst., PG Education, Pitt., 1188 Scaife Hall, Pittsburgh 15213.

May 6, 1970; Allentown

I/AMA—**The Expanding Parameters of Medicine: Holography-Telemetry** (8 week Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

May 7, 1970; Altoona Hospital

I/AMA—**Short Course in Cardiac Auscultation** (Program of Continuing Medical Education—twice monthly); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 7, 1970; Pottsville Hospital

I/AMA—**Modern Management of Shock** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 14, 1970; Allentown Hospital

I/AMA—**Use of Antibiotics** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

June 4, 1970; Pottsville Hospital

I/AMA—**Thrombophlebitis—Incidence, Risks, Treatment** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

June 11, 1970; Allentown Hospital

I/AMA—**Advances in the Concepts of Chemotherapy** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

GENETICS

December 11, 1969; Allentown Hospital

I/AMA—**Genetics** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

GERIATRICS

March 18, 1970; Scranton

I/AMA—**The Care of the Geriatric Patient Requiring Surgery** (Program of Continuing Medical Education—3rd Wed. ea. mo., 8 mos.); by Jefferson & Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

February 18, 1970; Reading

I/AMA—**Newer Concepts in the Diagnosis and Management of Leukemia** (Continuing Education Program—3rd Wed. ea. mo., 8 mos.); by Hahnemann; at Community Gen. Hosp. Contact Paul K. Stolz, M.D., Dir., Cont. Educa., Community Gen. Hosp., 135 N. 6th St., Reading 19601.

May 19, 1970; Chester

I/AMA—**The Hematologic Curse of Modern Drug Therapy** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 26, 1970; Chester

I/AMA—**Hematologic Manifestations of Systemic Disease** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

INTERNAL MEDICINE

December 3, 1969; Allentown

I/AMA—**Electrolyte Roulette** (8 week Education Program—1st Wed. ea. mo.); by U. of P.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

December 4-5, 1969; Erie

I/AMA—**Chronic Leukemia: Diagnosis and Treatment** (Program of Continuing Medical Education—twice a month, Sept.-Dec.); by Jefferson and Penn State; at St. Vincent Hosp., 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

December 16, 1969; Chester

I/AMA—**Clinical Problems in Acid-Base Balance** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

Education

December 17, 1969; Reading

I/AMA—**Rational Use of Antibiotics** (Continuing Education Program — 3rd Wed., 8 mos.); by Hahnemann; at Community General Hosp. Contact Paul K. Stolz, M.D., Dir., Cont. Educa., Community Gen. Hosp., 135 N. Sixth St., Reading 19601.

December 23, 1969; Chester

I/AMA—**The Initial Evaluation of the Patient with Renal Disease** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 5, 1970; Philadelphia

I/AMA—**Acute Ventilatory Insufficiency** (Program of Continuing Medical Education—1st Mon., 8 mos.); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAPG credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 6, 1970; Lebanon

I/AMA—**Diagnosis of the Acute Abdomen: More Than Appendicitis** (Continuing Medical Education Program—1st Tues., 4 mos.); by Jefferson and Penn State; at Quentin Riding Academy; 2 hrs. AAGP credit; $8 fee ($35 for 4 sessions). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 8, 1970; York Hospital

I/AMA—**Concepts of the Pineal Gland in Menstruation** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 22, 1970; York Hospital

I/AMA—**Current Therapy of Fluid and Electrolyte Homeostasis** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

February 2, 1970; Philadelphia

I/AMA—**Clinical Pharmacologic Basis of Use of Diuretics** (Program of Continuing Medical Education—1st Mon., 8 mos.); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 4, 1970; Allentown

I/AMA—**How Will Central Venous Pressure Help My Patient?** (8 week Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

March 10, 1970; Chester

I/AMA—**Clinical Implications of New Discovered Hormonal Agents** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 6, 1970; Philadelphia

I/AMA—**Evaluation and Treatment of Hypertensive Emergencies** (Program of Continuing Medical Education—1st Mon., 8 mos.); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 15, 1970; Reading

I/AMA—**Marital and Sexual Counseling for the Internist** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Community General Hosp. Contact Paul K. Stolz, M.D., Dir., Cont. Ed., Community Gen. Hosp., 135 N. 6th St., Reading 19601.

May 4, 1970; Philadelphia

I/AMA—**Extra Cranial Vascular Occlusions** (Program of Continuing Medical Education); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut So., Philadelphia 19107.

MENTAL RETARDATION

April 13-17, 1970; Elwyn

C—**Fourth Annual Symposium on Mental Retardation;** at Elwyn Institute; 7 hrs. each day; $25 fee. Contact Gerald R. Clark, M.D., President, Elwyn Institute, 111 Elwyn Rd., Elwyn 19063.

METABOLISM

December 30, 1969; Chester

I/AMA—**The Problem of Hyponatremia** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Penn State and Jefferson; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 6, 1970; Chester

I/AMA—**Aldosterone** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

NEUROLOGY

April 8, 1970; Philadelphia

C/AMA—**Teaching Day in Neurology;** at Albert Einstein Medical Center; 6 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 19141.

OBSTETRICS & GYNECOLOGY

December 2, 1969; Chester

I/AMA—**The Pill—More Than The Answer to a Maiden's Prayer?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 5-6, 1969; Philadelphia

C/AMA—**Social Problems in Obstetrics and Gynecology;** at Jefferson; 10 hrs. AAGP credit applied for; $40 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 15, 1970; Wilkes-Barre General Hospital

I/AMA—**The Pill—More Than the Answer to a Maiden's Prayer?** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 11, 1970; Philadelphia

C/AMA—**Contraception and Management of the Infertile Couple;** at Albert Einstein Medical Center; 5 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 19141.

April 30, 1970; York Hospital

I/AMA—**Pathophysiology of Fallopian Tube Function** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

OPHTHALMOLOGY

April 15-17, 1970; Pittsburgh

C/S—**Ophthalmic Micro Surgery;** by Pitt; at Eye and Ear Hospital; 8 hrs. each day; $350 fee; Maximum registration—12. Contact Kenneth T. Richardson, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

April 20-22, 1970; Pittsburgh

C/S—**The Glaucomas;** by Pitt; at Eye and Ear Hospital; 8 hrs. each day; $150 fee; Maximum registration—20. Contact Kenneth T. Richardson, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

August 3-7, 1970; Pittsburgh

C/S—**The Management of Retinal Detachment;** by Pitt; at Eye & Ear Hosp.; 8 hrs. ea. day; $250 fee; max. regis.: 12. Contact Wm. G. Everett, M.D., Eye and Ear Hosp., 230 Lothrop Street, Pittsburgh 15213.

ORTHOPAEDICS

March 19, 1970; York Hospital

I/AMA—**Concepts of Bone Healing** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PEDIATRICS

December 11, 1969; York Hospital

I/AMA—**Selected Aspects of Neonatology** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; York Hospital

I/AMA—**The Delivery of Care to Pediatric Patients** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 18, 1969; Williamsport Hospital

I/AMA—**Urologic Problems in Children** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 29, 1970; York Hospital

I/AMA—**Present Concepts of Pediatric Immunology** (Program of Continuing Medical Education Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

February 18, 1970; Scranton

I/AMA—**Pediatric Surgery** (Program of Continuing Medical Education—3rd Wed. ea. mo., 8 mos.); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 2, 1970; Philadelphia

I/AMA—**Pediatric Office Emergencies** (Program of Continuing Medical Education—1st Mon., 8 mos.); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 12, 1970; York Hospital

I/AMA—**What's New in Infectious Diseases in Children** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 31, 1970; Johnstown

I/AMA—**Neonatal Respiratory Syndromes** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 12-15, 1970; Philadelphia

C—**19th Annual Pediatric Postgraduate Seminar;** at St. Christopher's Hospital for Children; 6 hrs. each day; $100 fee. Contact John B. Bartram, M.D., Director, Division of Service to Handicapped, St. Christopher's Hospital, 2600 N. Lawrence St., Philadelphia 19133.

PHYSIOLOGY

April 2, 1970; York Hospital

I/AMA—**Physiology of Renal Function, Revisited** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Associate Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

April 9, 1970; York Hospital

I/AMA—**The Physiology of Contractility and Cardiac Failure** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 9-11, 1970; Philadelphia

C/AMA—**Current Concepts in Physiology of the Gastrointestinal, Endocrine and Respiratory Systems;** by American College of Physiology and American Physiological Society; at Holiday Inn; $60 fee—ACP members ($100, nonmembers). Contact Daniel H. Simmons, M.D., Director, ACP, 4200 Pine Street, Philadelphia 19104.

education

April 23, 1970; York Hospital

I/AMA—**The Physiology of Acidosis** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Fourth Friday each month, September, 1969—June, 1970; Butler

I—**Physician-Community Psychiatrist Seminar;** by Mental Health Guidance Clinic of Butler Co.; at YWCA; Hour for hour AAGP credit. Contact Robert L. Eisler, M.D., Mental Health Guidance Clinic. 128 S. Main St., Butler 16001.

January 1, 1970 to February 11, 1970 (Each Wednesday); Philadelphia

I—**Depression and Suicide;** at Institute of Pa. Hosp., 18 hrs. AAGP credit. $25 fee. Contact Sydney E. Pulver, M.D., Program Director, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

January 14—March 18, 1970; Philadelphia

I/AMA—**Clinical Seminars in Medical Psychiatry (Advanced);** at Hahnemann—Each Wednesday, 10 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

February 18—May 13, 1970; Philadelphia

I—**Advanced Applied Office Psychiatry;** at the Institute of Pennsylvania Hospital—Each Wednesday, 12 weeks; 48 hrs. AAGP credit; $50 fee. Contact Sydney E. Pulver, M.D., The Institute, 111 N. 49th St., Philadelphia 19139.

February 19, 1970; Pottsville

I/AMA—**Differential Diagnostic Considerations of Psychosomatic Disorders** (Continuing Education Program — 3rd Wed., 8 mos.); by Hahnemann; at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

February 24, 1970; Johnstown

I/AMA—**Psychotherapeutic Drugs** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St. Philadelphia 19107.

March 5, 1970; York Hospital

I/AMA—**Pathophysiology of Schizophrenia** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Wilkes-Barre General Hospital

I/AMA—**Battle of the Sexes—Is Marriage Worth Saving?** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 1—June 3, 1970; Philadelphia

I/AMA—**Clinical Seminars in Medical Psychiatry (Advanced);** at Hahnemann—Each Wednesday, 10 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

RADIOLOGY AND RADIOISOTOPES

May 5, 1970; Chester

I/AMA—**The Use of Isotopes in Medicine** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 12, 1970; Chester

I/AMA—**Heavy Dose Irradiation—When Does it Palliate?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 26, 1970; Johnstown

I/AMA—**Newer Diagnostic Aspects in Radiology** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

SURGERY

January 15, 1970; York Hospital

I/AMA—**Present Concepts of Surgical Ulcer Treatment** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 18—March 25, 1970; Philadelphia

I/AMA—**Office Surgery;** Each Tuesday, 6 weeks; at Albert Einstein Medical Center; 18 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

UROLOGY

January 13, 1970; Chester

I/AMA—**Home Dialysis** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 20, 1970; Chester

I/AMA—**The Kidney, Bones and Stones** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson 1025 Walnut St., Philadelphia 19107.

March 18, 1970; Philadelphia

C/AMA—**Developments in Kidney Disease;** at Albert Einstein Medical Center; 6 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 19141.

April 16, 1970; Wilkes-Barre General Hospital

I/AMA—**Surgical Aspects of Inflammatory Diseases of the Bowel** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

obituaries

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Andrew R. Chancellor,** Pittsburgh; University of Pittsburgh School of Medicine, 1914; age 79; died September 7, 1969. He received the PMS Fifty-Year Award in 1964. He is survived by his wife, a son and two daughters.

○ **William I. Gash,** Philadelphia; University of Pennsylvania School of Medicine, 1923; age 70; died September 11, 1969. He was a veteran of World War I and had served as vice-president of the Philadelphia County Medical Society. Surviving are his wife, Ruth, two sons, one of whom is Robert P. Gash, M.D., two sisters and two brothers.

○ **Orville F. George,** South Fork; Hahnemann Medical College, 1921; age 76; died August 23, 1969. He had served as chief of the medical staff at Lee Hospital, Johnstown, and as school physician for the Forest Hills School District. He is survived by his wife, a daughter and a son, John O. George, M.D.

○ **John Patrick Gibbons,** Wilkes-Barre; Georgetown University School of Medicine, 1938; age 62; died September 1, 1969. Dr. Gibbons had served as Luzerne County Coroner for the past six years. He served in the Navy Medical Corps during World War II. Surviving are his wife and a son.

○ **Florence M. Kline,** Duarte, Calif.; Woman's Medical College of Pennsylvania, 1904; age 87; died August 28, 1969. She retired from active practice in 1959 and moved to California from West Deer Township, after more than fifty years of service in and around the Pittsburgh area. She is survived by a brother.

○ **Theodore Lidle,** Havertown; University of Pennsylvania School of Medicine, 1929; age 65; died August 30, 1969. Surviving are his wife, three daughters, one of whom is Faith Skattum, M.D., and a brother.

○ **Arthur C. McKinley,** Brookville; University of Pittsburgh School of Medicine, 1908; age 91; died August 14, 1969. He spent close to sixty years in the practice of medicine in Clarion and Jefferson Counties. He received the PMS Fifty-Year Award in 1958, and in 1967 was named "Brookville Man of the Year" by the Chamber of Commerce. Four sons, all of whom survive him, followed their father's footsteps in the medical profession, practicing in and around Brookville. They are Drs. A. Random, Oscar V., Wayne S., and William Mark McKinley. Also surviving are three daughters and two sisters.

○ **Norman H. Miller, Jr.,** Pittsburgh; University of Pittsburgh School of Medicine, 1953; age 46; died August 26, 1969. He served as an Air Force physician during World War II: Survivors include his mother and a brother.

○ **Harry W. Millikin,** Sarasota, Fla.; University of Pennsylvania School of Medicine, 1914; age 80; died September 2, 1969. He had served as a physician in Sharon for forty-two years prior to his retirement in 1957. He is survived by his wife.

○ **John McK. Mitchell,** Bryn Mawr; Yale University School of Medicine, 1924; age 74; died September 18, 1969. The pediatrician and educator had served as dean of the University of Pennsylvania School of Medicine from 1948 to 1962. He then served as director of medical education for Bryn Mawr Hospital until his retirement in 1966. He received many awards, including the Abraham Jacobi Award of the AMA in 1964. He served in both World Wars. He is survived by his wife, a daughter, a son and three stepsons, including F. Taylor Mauck, M.D.

○ **Charles C. Moore, Jr., M.D.,** Oakmont; University of Pittsburgh School of Medicine, 1947; age 45; died September 10, 1969. He was a Fellow of the American College of Surgeons. Surviving are his wife, three sons, two daughters, his father, Charles C. Moore, Sr., M.D., and a sister.

○ **Meyer W. Rubenstein,** Pittsburgh; Jefferson Medical College, 1923; age 69; died September 7, 1969. He was clinical associate professor of dermatology at the University of Pittsburgh School of Medicine and was a member of the Allegheny County Dermatological Association. He is survived by his wife, a son, Mark M. Rubenstein, M.D., San Francisco, Calif., a daughter and a brother.

○ **Charles J. Stybr,** Pittsburgh; Jefferson Medical College, 1900; age 91; died August 29, 1969. He is survived by his wife and daughter.

○ **William C. Taft,** Carlisle; Jefferson Medical College, 1940; age 54; died September 11, 1969. He served as a medical officer in the Army Air Force during World War II. He is survived by two daughters and a sister.

○ **Leo A. Wajert,** Pittsburgh; Creighton University Medical School, Omaha, Neb., 1935; age 64; died September 3, 1969. He practiced on the southside of Pittsburgh for more than thirty years. He is survived by his wife and a son.

○ **Theodore Wollak,** Scottdale; University of Maryland Medical School, Baltimore, Md., 1927; age 65; died September 15, 1969. He is survived by his wife, a daughter, two sisters, and a brother, Charles E. Wollak, M.D.

Samuel Chartock, Philadelphia; University of Pennsylvania School of Medicine, 1917; age 73; died September 8, 1969. He is survived by his wife, two daughters, a son, two brothers and a sister.

Robert T. Gildea, Tupper Lake, N. Y.; Hahnemann Medical College, 1948; age 47; died September 15, 1969. In 1966 he served as a Volunteer Physician in Vietnam under the AMA program. He was an associate member of the American Psychiatric Association. He is survived by his wife, four sons, one daughter and two bothers, one of whom is James E. Gildea, M.D., Chicago, Ill.

Morris Segal, Philadelphia; Jefferson Medical College, 1917; age 74; died August 24, 1969. In 1967 he was awarded the PMS Fifty-Year Award. He served in France and Germany during World War I. Surviving are his wife, a son and two sisters.

meetings

DECEMBER

Arthritis Foundation, Allied Health Professions, December 4, 1969; American Rheumatism Association Interim Scientic Session, December 5-6, 1969, Pioneer Hotel, Tucson, Ariz.

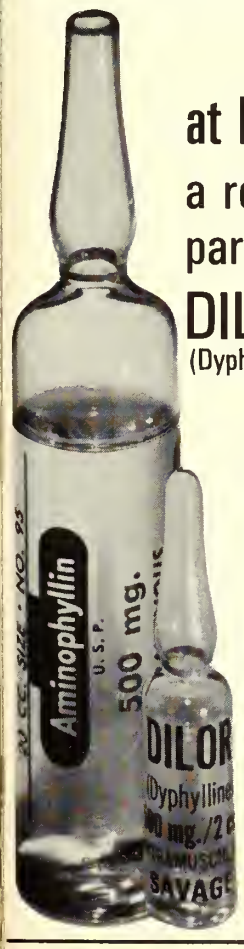
Annual Meeting, American Academy of Psychoanalysis, December 5-7, 1969, New York City.

Twenty-eighth Annual Meeting, American Academy of Dermatology, December 6-11, 1969, Americana Hotel, Bal Harbour, Fla.

Annual Meeting, American Society of Hematology, December 7-9, 1969, Cleveland, Ohio.

Annual Meeting, American Public Welfare Association, December 10-13, 1969, Dallas, Tex.

Annual Meeting, American Psychoanalytic Association, December 12-14, 1969, New York City.



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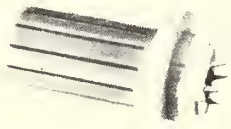

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Physician for Student Health Service. Easy hours, pleasant work, excellent fringe benefits. Equal opportunity employer. Write: Director, Student Health Service, Lehigh University, Bethlehem, Pa. 18015.

Emergency Room physicians needed for full-time staffing. Ideal for the new graduate or for the experienced physician wishing to slow down. Write ADMINISTRATOR, Sharon General Hospital, Sharon, Pa.

Physician needed at Laurelton State School and Hospital, Laurelton, Pennsylvania. Emphasis is on rehabilitation of the mentally retarded, with active medical, paramedical, educational and vocational programs. Associated with an approved general hospital with consultation services available in all medical specialties. Located in beautiful Buffalo Valley, with excellent outdoor recreational facilities, rural living, and six institutions of higher learning within an hour's drive. Apply Superintendent, Laurelton State School and Hospital, Laurelton, Pa. 17835. Telephone (717) 922-3311.

Beautiful Bedford County needs physicians in private practice. Excellent opportunity. Well-equipped local hospital with open staff expanding to 115 beds with four-bed ICC unit. Resort community with newly acquired light and heavy industry. Hunting, fishing, skiing, boating and three golf courses. Excellent school system. No big-city problems. Two hours from Harrisburg, Pittsburgh, Washington, D. C. Contact M.D. Search Committee, Memorial Hospital of Bedford County, R. D. 1, Everett, Pa. 15537.

Psychiatrist wanted to assume medical directorship of autonomous Community Mental Health Center situated on the grounds of Friends Hospital in northeast Philadelphia. Dynamic, creative professional wanted to work in a multidisciplinary setting in a new facility. Will be responsible for a broad spectrum of duties including policy formulation, recruitment, and supervision of chiefs of professional services. Applicant should have broad administrative experience preferably with training in community mental health work. Excellent working conditions and fringe benefits. Salary open. Contact Mr. Paul D. Grubb, Chairman, Personnel Committee, Northeast Community Mental Health Center, Roosevelt Blvd. and Adams Avenue, Phila., Pa., 19124.

Physicians in general medicine wanted—active 200-bed GM&S hospital. Liberal vacation, sick leave, health benefits, and retirement plan. Board certified or qualified preferred. GP with good background in internal medicine considered. U. S. citizenship preferred and license any state required. Equal opportunity employer. Contact Hospital Director, Veterans Administration Hospital, Erie, Pa. 16504.

Physician in General Medicine wanted: Active 200-bed GM&S hospital. Liberal vacation, sick leave, health benefits and retirement plan. Board certified or qualified preferred. GP with good background in internal medicine considered. U. S. citizenship preferred and license any state required. Equal opportunity employer. Contact Hospital Director, Veterans Administration Hospital, Altoona, Pa. 16603.

Director of Coronary Care Unit: Are you a board certified or eligible cardiologist, or a board certified or eligible internist with at least one additional year of formal training in cardiology? We are seeking such a man to be chief of our coronary care unit. Currently a three-bed unit completely separated from ICU is in the process of completion and a five-bed unit in our new building addition is scheduled to open in 1972. Duties consist of directing the present unit and actively participating in completion of the new unit. Unit staffed by formally trained CC nurses. Address all inquiries to Administrator, Charleroi-Monessen Hospital, North Charleroi, Pa. 15022—Telephone (412) 483-5561.

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Mental Hospital Director—mid-state location combines best of urban and rural. Salary to $27,697. Active treatment program in 690-bed facility. Community programs developing. Minimum six years in psychiatry with four in administrative or supervisory capacity. Write: Harry H. Negley, Jr., M.D., Chairman, Board of Trustees, Hollidaysburg State Hospital, P. O. Box 319, Hollidaysburg, Pa. 16648

Wanted: Emergency room physician to augment existing emergency room staff in 250-bed general hospital. Pennsylvania license required; forty two hours per week. Fee for service with minimum guarantee of $28,000 annually; medical staff appointment. Write or call Administrator, Lee Hospital, Johnstown, Pa. 15901. Telephone (814) 535-1511.

House Physician wanted: 221-bed general hospital; Pennsylvania license required. Salary negotiable. Position available now. Contact Medical Director, Frankford Hospital, Philadelphia 19124. Telephone (215) JE-3-9400.

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Wanted: General Practice or Association. GP, age 41, available February, 1970, prefers family practice with Workmens' Compensation. All details first letter please. Sanford Pinna, M.D., New Rochelle Hospital, New Rochelle, N. Y. 10801.

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Practice for general practitioner or internist for sale: northwestern Pennsylvania; grossing $7,000 per month. No surgery or obstetrics; leaving to specialize; available January 1, 1970. Open staff hospital—all recreational activities available. Write Department 566, PENNSYLVANIA MEDICINE.

Internal Medicine practice for sale; will introduce. Florida license required. Write P.O. Box 4481, Miami Beach, Fla. 33141.

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in my opinion

Changing Patterns in the Doctor-Nurse Relationship

Organized nursing existed in ancient times, chiefly in leprosaria and pest houses. Care was entirely custodial and interestingly enough, the institutions were independent of physicians.

In 1856, shortly after the Crimean War, Florence Nightingale started the first school of nursing. It was not affiliated with a hospital, and it was not until 1880 that hospital schools of nursing were established. From that time, the number of nurses increased rapidly, and now in the United States there are over 582,000 professional nurses, of whom 67 per cent work in hospitals and related institutions.

From the time of the first association of nurses and doctors, a fixed pattern was established. The doctor initiated treatment and the nurses carried out the orders. The duties of the nurses were carefully limited, and in general there was little opportunity for independent activity. Even as recently as twenty years ago, the nurses' duties in the hospital were almost exclusively patient care—baths, enemas, temperature recordings, changing of linens, and to a modest extent dispensing of drugs and keeping records. More recently however, with ever increasing modalities of diagnosis and treatment, plus the critical shortage of physicians, many of the physician's tasks have been transferred by default to the nurse. Formerly the nurse was only permitted to inject specified drugs under the skin. Now at the Massachusetts General Hospital, a group of specially trained nurses give all intravenous therapy including drugs, fluids and blood. More important, they perform these tasks with more skill and efficiency than was previously demonstrated by the average physician, and it is anticipated that in the future nurses or other super technicians will do spinal taps, paracenteses, thoracenteses and minor surgery. Even now in certain rural areas public health nurses make home visits, evaluate patients, treat minor illnesses, and refer patients requiring definitive medical care to appropriate physicians. These nurses accept responsibility very close to that of the general practitioner. They act as the doctor's emissary, and they perform a creditable and necessary service.

The hospital nurses' primary role has now shifted from patient care to administration. She supervises the ancillary nursing staff, administers drugs, keeps extensive hospital and patient records, visits with patients, deals with distraught families and keeps the physician informed of changes in the patient's condition. In this sense the nurse has become less a nurse in the traditional sense, and more the physician's assistant.

According to a recent survey only one-third of the total hours of nursing care in hospitals is provided by professional nurses; the remainder by licensed practical nurses, orderlies and nurses aides. Although physicians still desire the personal care of patients by registered nurses, they hardly expect it under prevailing circumstances.

The new role of the nurse may require some specialized training not included in the present curriculum. But even now much is being accomplished by "on the job training." The nurse accompanies the physician on his rounds where she is informed of diagnoses and the rationale of therapy. The good registered nurse on the floor is becoming increasingly knowledgeable in pharmacology, including average doses of drugs and particularly in allergic and toxic drugs reactions. This expertise is necessary, for she sees the patient innumerable times during the day, contrasted with the few minutes spent by the physician, and she is able to recognize subtle changes in the patient and to report these changes to the physician.

As proof, the following conversation recently was reported at one of our hospitals. "Doctor, this patient has been on .25 mgs of digoxin daily for fourteen days. His pulse is forty with coupling of beats and he is nauseated. Do you wish to discontinue the medication?" This is a good example of changing patterns.

In a recently published book, *Sickness and Society*, the authors, Raymond S. Duff, M.D. and August B. Hollingshead, Ph.D., present an expert in-depth survey of a large, unnamed American hospital. The following quotation from the book sums up the new attitude: "It is advisable for the attending physicians to sit down with the floor nurse and discuss the patients. He can learn much and quickly."

H. J. Levin, M.D.
Washington County Medical Bulletin

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Antihistamine			●		
Long-Acting (6-8 hours)		●			●
Nasal, Sinus Decongestant				●	
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A list of educational opportunities offered to physicians in the interest of maintaining their competence and skill. Unless otherwise indicated, all courses are designed for physicians engaged in primary patient care.

ADOLESCENTS' MEDICAL CARE

February 26, 1970; York Hospital

I/AMA—**Occurrence and Genesis of Abnormal Menstruation at Puberty** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

ANESTHESIOLOGY

March 7, 1970; Cherry Hill Inn (N. J.)

C/S—**11th Annual Postgraduate Anesthesia Seminar;** by N. J. State Soc. of Anesthesiologists; $4 fee ($14 for nonmembers of NJSSA). Contact Bertram H. Shapiro, M.D., NJSSA, 180 E. 21st St., Paterson, N.J. 07513.

ARTHRITIS AND RHEUMATISM

February 11, 1970; Philadelphia

C/AMA—**Rheumatoid Arthritis;** at Albert Einstein Med. Center; 6 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chrm., Albert Einstein Med. Center, York & Tabor Rds., Philadelphia 19141.

CARDIOVASCULAR DISEASE

December 9, 1969; Chester

I/AMA—**Clinical Applications of Cardiac Catherization** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 17, 1969; Scranton

I/AMA—**Pre and Postoperative Problems in the Patient Subjected to Cardiac Surgery** (Program of Continuing Medical Education—3rd Wed. ea. mo., 8 mos.); by Jefferson and Penn State at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Wilkes-Barre General Hospital

I/AMA—**Acute Stroke Syndrome** (Program of Continuing Medical Education—One Thursday Each Month); by Jefferson & Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Associate Dean, Jefferson, 1025 Walnut St., Phila. 19107.

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Pitt P.H.—University of Pittsburgh Graduate School of Public Health
Penn State—Pennsylvania State University
Temple—Temple University Health Sciences Center
U. of Pa.—University of Pennsylvania School of Medicine
Woman's—Woman's Medical College of Pennsylvania

January 7, 1970; Allentown

I/AMA—**How to Avoid Code Blues? (Cardio Respiratory Collapse);** (8 weeks Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP Credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

January 8, 1970; Allentown Hospital

I/AMA—**Heart Sounds** (Program of Continuing Medical Education, 2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 22, 1970; Pottsville

I/AMA—**Intractable Congestive Heart Failure** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

January 27, 1970; Chester

I/AMA—**Anticoagulants in Cardiovascular Disorders** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; York Hospital

I/AMA—**New Concepts in Cardiac Surgery** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

March 4, 1970; Allentown

I/AMA—**Integrated Management of the Patient with Cardiogenic Shock** (8 week Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp.; Allentown 18102.

March 18, 1970; Reading

I/AMA—**The Management of the Hypertensive Patient Undergoing General Surgery** (Continuing Education Program—3rd Wed., 8 months); by Hahnemann at Community General Hosp. Contact Paul K. Stolz, M.D., Dir., Continuing Educa., Community Gen. Hosp., 135 N. 6th St., Reading 19601.

March 19, 1970; Williamsport Hospital

I/AMA—**Coronary Artery Disease; Pre-Infarction and Post-Infarction. Problems of Recognition and Management** (Postgraduate Seminars held 3rd Thurs. ea. mo.); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 21, 1970; Wilkes-Barre General Hospital

I/AMA—**Drugs and the Heart** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

CHEST DISEASES

January 21, 1970; Reading

I/AMA—**Respiratory Failure** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Community General Hosp. Contact Paul K. Stolz, M.D., Dir. Cont. Educa., Community Gen. Hosp., 135 N. 6th St., Reading 19601.

January 21, 1970; Scranton

I/AMA—**Pre and Postoperative Problems in the Patient with Pulmonary Disease** (Program of Continuing Medical Education—3rd Wed. ea. mo.; 8 mos.); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 4—March 25, 1970; Philadelphia

I/AMA—**Diagnosis and Management of Chronic Respiratory Disease** (Each Tuesday—8 weeks); at Albert Einstein Medical Center; 20 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

February 9-20, 1970; Philadelphia (Repeat April 6-17, 1970)

PG/AMA—**Postgraduate Course in Bronchoesophagology;** at Temple; for chest physicians, thoracic surgeons, anesthesiologists and gastroenterologists. $350 fee. Contact Chevalier Jackson Clinic, Temple, 3401 N. Broad St., Philadelphia 19140.

March 17, 1970; Chester

I/AMA—**Pulmonary Infiltrates: TB or Not TB?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 24, 1970; Chester

I/AMA—**The Use and Abuse of Oxygen Therapy** (Program of Continuing Medical Education Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 31, 1970; Chester

I/AMA—**The Solitary Pulmonary Nodule;** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 21, 1970; Pottsville

I/AMA—**Acute Respiratory Failure; Diagnosis & Management** (Cont. Education Program 3rd Wed., 8 mos.); by Hahnemann at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

DERMATOLOGY

April 16, 1970; York Hospital

I/AMA—**Dermatologic Drug Reactions and Their Pathophysiology** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

ELECTROCARDIOGRAPHY

January 25 and February 1, 1970; Pittsburgh

I—**Electrography—Newer Concepts;** by Pitt. and West Penn and Shadyside Hosps.; at West Penn (1/25/70) and Shadyside (2/1/70); 5 hrs. AAGP credit, $15 fee (both Sundays). Contact John B. Hill, M.D., West Penn Hosp., 4800 Friendship Ave., Pittsburgh 15224.

February 25—April 29, 1970; Philadelphia

I/AMA—**Advanced Electrocardiography;** Each Tuesday, 10 weeks; at Albert Einstein Medical Center, 30 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

ENDOCRINOLOGY

January-May, 1970 (3rd Thurs. ea. mo.); Bethlehem

I—**Endocrinology: Medical and Surgical Aspects;** at St. Luke's Hosp., by Jefferson; 24 hrs. AAGP credit; $24 fee (6 seminars), $7 ea. Contact Michael L. Sheppeck, M.D., Med. Dir., St. Luke's Hosp., Bethlehem 18015.

January 15, 1970; Bethlehem;

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Pituitary Gland;** (Program of Continuing Medical Education); By Jefferson and Penn State at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

February 3, 1970; Chester

I/AMA—**The Problem Diabetic** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 10, 1970; Chester

I/AMA—**Thyroid Function Tests—How to Evaluate Them** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D. M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 17, 1970; Chester

I/AMA—**Thyroid Nodule—When Not to Operate** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Thyroid Gland.** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital, 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia.

February 24, 1970; Chester

I/AMA—**The Outpatient Management of Anemia** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 1, 1970; Pittsburgh

C—**Diagnosis and Treatment of Endocrine Abnormalities in the Female;** by Pitt and West Penn and Shadyside Hosps.; at West Penn Hosp.; 5 hrs. AAGP credit; $15 fee. Contact John B. Hill, M.D., West Penn Hosp., 4800 Friendship Ave., Pittsburgh 15224.

March 4, 1970; Chester

I/AMA—**Enigma of Hypoglycemia** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Parathyroid Gland.** (Program of Continuing Medical Education) by Jefferson & Penn State at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Phila. 19107.

March 19, 1970; Pottsville

I/AMA—**Modern Treatment of Diabetes** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

March 22, 1970; Pittsburgh

C—**Diagnosis and Treatment of Endocrine Abnormalities in the Male;** by Pitt and West Penn and Shadyside Hosps.; at West Penn Hosp.; 5 hrs. AAGP credit; $15 fee. Contact John B. Hill, M.D., West Penn Hosp., 4800 Friendship Ave., Pittsburgh 15224.

March 26, 1970; York Hospital

I/AMA—**What's New in Endocrinol-**

ogy (Program of Continuing Medical Education—Each Thursday, 3 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 16, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Adrenal Gland** (Program of Continuing Medical Education) by Jefferson and Penn State; at St. Luke's Hospital, 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Phila. 19107.

April 16, 1970; Pottsville

I/AMA—**Treatment of Hyperthyroidism** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

April 28, 1970; Johnstown

I/AMA—**Obesity** (Program of Continuing Medical Education—Last Tuesday—7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 7, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Ovary** (Program for Continuing Medical Education); by Jefferson and Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 15, 1970; Scranton

I/AMA—**The Diabetic and Surgery** (Program of Continuing Medical Education—3rd Wed. ea. mo. 8 mos.); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 20, 1970; Reading

I/AMA—**Adrenal Disorders** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Community General Hosp. Contact Paul K. Stolz, M.D., Dir., Cont. Educa., Community General Hosp.; 135 N. 6th St., Reading 19601.

May 21, 1970; Bethlehem

I/AMA—**Medical and Surgical Approaches to Endocrine Diseases: Tumors of Nonendocrine Origin** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital; 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Phila. 19107.

GASTROENTEROLOGY

February 19, 1970; Williamsport Hospital

I/AMA—**Dilemmas of a Belly Ache** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 9, 1970; Allentown Hospital

I/AMA—**Ulcerative Colitis** (Program of Continuing Medical Education, 2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 14, 1970; Chester

I/AMA—**Inflammatory Diseases of the Bowel** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 15, 1970; Scranton

I/AMA—**Preparation of and Postoperative Care of the Patient Requiring Surgery of the Hepato-Biliary Tract** (Program of Continuing Medical Education—3rd Wed. ea. mo., 8 mos.); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 21, 1970; Chester

I/AMA—**The Irritable Colon Syndrome and Diverticular Disease of the Colon** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 29, 1970; Chester

I/AMA—**Immunoglobulins and the GI Tract** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

June 1, 1970; Philadelphia

I/AMA—**Chronic Hepatitis** (Program of Continuing Medical Education); by Jefferson and Penn State; at Methodist Hospital; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

GENERAL MEDICINE

Every Thursday; Hazleton State General Hospital

I—**Program of Continuing Medical Education by Hazleton Branch, Luzerne County Medical Society.** Contact Robert Gunderson, M.D., Suite 412 Northeastern Building, Hazleton, Pa. 18201.

December 4, 1969; Altoona Hospital

I/AMA—**Innocent Murmurs in Children;** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 4, 1969; Pottsville Hospital

I/AMA—**The Pill—More Than the Answer to a Maiden's Prayer** (Program of Continuing Medical Education—1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 9-12, 1969; Philadelphia

C/AMA—**Emergencies in Medical Care;** by Hahnemann; at Marriott Motor Hotel; 56 hrs. AAGP credit applied for; $150 fee—paramedics $35. Contact Stanley Spitzer, M.D. or Wilbur W. Oaks, M.D., Hahnemann, 230 North Broad St., Philadelphia 19102.

December 12, 1969; Williamsport Hospital

I/AMA—**Current Concepts of Thyroid Disease** (Program of Continuing Medical Education 2nd Fri. each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 15, 1969; Johnstown

I/AMA—**Drug Reactions** (Program of Continuing Medical Education—3rd

Monday—7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Altoona Hospital

I/AMA—**Approach to the Patient with Fever of Unknown Origin** (Pro—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; Bethlehem

I/AMA—**Immunologic Basis for Drug Reactions** (Program of Continuing Medical Education); by Jefferson & Penn State; at St. Luke's Hospital, 3 hrs. AAGP credit. $7 fee ($44 for series of 11). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18-19, 1969; Erie

I/AMA—**Autoimmune Disease** (Program of Continuing Medical Education —twice a month, Sept.-Dec.); by Jefferson and Penn State; at St. Vincent Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

January 8, 1970; Pottsville Hospital

I/AMA—**Chronic Leg Ulcers** (Program of Continuing Medical Education —1st Thursday Each Month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

January 15, 1970; Altoona Hospital

I/AMA—**Newer Diagnostic Techniques in Radiology** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

February 3, 1970; Lebanon

I/AMA—**Adolescent Psychiatry** (Continuing Medical Education Program—1st Tues., 4 mos.); by Jefferson and Penn State; at Quentin Riding Academy; 2 hrs. AAGP credit; $8 fee ($35 for 4 sessions). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 5, 1970; Altoona Hospital

I/AMA—**Current Theories Concerning Causation of Cancer** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

February 5, 1970; Pottsville Hospital

I/AMA—**Hepatitis** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 3, 1970; Lebanon

I/AMA—**Use and Misuse of Anti-Biotics** (Continuing Medical Education Program—1st Tues., 4 mos.); by Jefferson and Penn State; at Quentin Riding Academy; 2 hrs. AAGP credit. $8 fee ($35 for 4 sessions). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 5—April 16, 1970; DuBois Hospital

I—**Current Medical and Surgical Concepts** (Program of Continuing Medical Education—Alternate Wednesdays, 11 sessions); by C E S; 33 hrs. AAGP credit applied for; $25 fee ($5 single session). Contact Co.M.E., Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne 17043.

February 5, 1970; York Hospital

I/AMA—**What's New in Antibiotics and Cardiac Drugs** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 12, 1970; Allentown Hospital

I/AMA—**Early Diagnosis of the Stroke Prone Patient** (Program of Continuing Medical Education—2nd Thursday, each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 12, 1970; York Hospital

I/AMA—**Pathophysiology of Hepatic Failure** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 13, 1970; Williamsport Hospital

I/AMA—**Surgical Aspects of Venous and Arterial Insufficiency of the Lower Extremities** (Program of Continuing Medical Education—2nd Friday of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Altoona Hospital

I/AMA—**Hyperlipodemias** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

February 19, 1970; Wilkes-Barre General Hospital

I/AMA—**Clinical Application of Scanning Techniques** (Program of Continuing Education—One Thursday each month); by Jefferson & Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

March 5, 1970; Altoona Hospital

I/AMA—**Management of The Pregnant Diabetic** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

March 5, 1970; Pottsville Hospital

I/AMA—**Infections of the Central Nervous System** (Program of Continuing Medical Education 1st. Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia.

March 12, 1970; Allentown Hospital

I/AMA—**State of Renal Transplants** (Program of Continuing Medical Education, 2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 13, 1970; Williamsport Hospital

I/AMA—**The Physician's Role in Sex Education** (Program of Continuing Medical Education 2nd Fri. of each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Altoona Hospital

I/AMA—**Aggressive Management of**

Patients with Stroke (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

April 1, 1970; Allentown

I/AMA—**Errors in Emergency Practice** (8 week Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

April 2, 1970; Altoona Hospital

I/AMA—**Emotional Problems at Adolescence** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Phila. 19107.

April 2, 1970; Pottsville Hospital

I/AMA—**Genetic Implications of Drugs and Radiation Exposure** (Program of Continuing Medical Education, 1st. Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 7, 1970; Chester

I/AMA—**Antibiotics—Uses and Abuses** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks; by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 16, 1970; Altoona Hospital

I/AMA—**Diagnosis of Anemia** (Program of Continuing Medical Education—twice a month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

May, 1970; Pitt

C—**Fourth Annual Symposium on Acute Medicine;** at Scaife Hall; 5 days; 40 hours AAGP credit applied for. Contact Sally Barr, Admin. Asst., PG Education, Pitt., 1188 Scaife Hall, Pittsburgh 15213.

May 6, 1970; Allentown

I/AMA—**The Expanding Parameters of Medicine: Holography-Telemetry** (8 week Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

May 7, 1970; Altoona Hospital

I/AMA—**Short Course in Cardiac Auscultation** (Program of Continuing Medical Education—twice monthly); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 7, 1970; Pottsville Hospital

I/AMA—**Modern Management of Shock** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 14, 1970; Allentown Hospital

I/AMA—**Use of Antibiotics** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

June 4, 1970; Pottsville Hospital

I/AMA—**Thrombophlebitis—Incidence, Risks, Treatment** (Program of Continuing Medical Education, 1st Thursday each month); by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

June 11, 1970; Allentown Hospital

I/AMA—**Advances in the Concepts of Chemotherapy** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

GENETICS

December 11, 1969; Allentown Hospital

I/AMA—**Genetics** (Program of Continuing Medical Education—2nd Thursday each month, 10 months); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

GERIATRICS

March 18, 1970; Scranton

I/AMA—**The Care of the Geriatric Patient Requiring Surgery** (Program of Continuing Medical Education—3rd Wed. ea. mo., 8 mos.); by Jefferson & Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

HEMATOLOGY

February 18, 1970; Reading

I/AMA—**Newer Concepts in the Diagnosis and Management of Leukemia** (Continuing Education Program—3rd Wed. ea. mo., 8 mos.); by Hahnemann; at Community Gen. Hosp. Contact Paul K. Stolz, M.D., Dir., Cont. Educa., Community Gen. Hosp., 135 N. 6th St., Reading 19601.

May 19, 1970; Chester

I/AMA—**The Hematologic Curse of Modern Drug Therapy** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 26, 1970; Chester

I/AMA—**Hematologic Manifestations of Systemic Disease** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

INTERNAL MEDICINE

December 3, 1969; Allentown

I/AMA—**Electrolyte Roulette** (8 week Education Program—1st Wed. ea. mo.); by U. of P.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

December 4-5, 1969; Erie

I/AMA—**Chronic Leukemia: Diagnosis and Treatment** (Program of Continuing Medical Education—twice a month, Sept.-Dec.); by Jefferson and Penn State; at St. Vincent Hosp., 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Jefferson, 1025 Walnut St., Philadelphia 19107.

December 16, 1969; Chester

I/AMA—**Clinical Problems in Acid-Base Balance** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

education

December 17, 1969; Reading

I/AMA—**Rational Use of Antibiotics** (Continuing Education Program — 3rd Wed., 8 mos.); by Hahnemann; at Community General Hosp. Contact Paul K. Stolz, M.D., Dir., Cont. Educa., Community Gen. Hosp., 135 N. Sixth St., Reading 19601.

December 23, 1969; Chester

I/AMA—**The Initial Evaluation of the Patient with Renal Disease** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 5, 1970; Philadelphia

I/AMA—**Acute Ventilatory Insufficiency** (Program of Continuing Medical Education—1st Mon., 8 mos.); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAPG credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 6, 1970; Lebanon

I/AMA—**Diagnosis of the Acute Abdomen: More Than Appendicitis** (Continuing Medical Education Program—1st Tues., 4 mos.); by Jefferson and Penn State; at Quentin Riding Academy; 2 hrs. AAGP credit; $8 fee ($35 for 4 sessions). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 8, 1970; York Hospital

I/AMA—**Concepts of the Pineal Gland in Menstruation** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 22, 1970; York Hospital

I/AMA—**Current Therapy of Fluid and Electrolyte Homeostasis** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

February 2, 1970; Philadelphia

I/AMA—**Clinical Pharmacologic Basis of Use of Diuretics** (Program of Continuing Medical Education—1st Mon., 8 mos.); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 4, 1970; Allentown

I/AMA—**How Will Central Venous Pressure Help My Patient?** (8 week Education Program—1st Wed. ea. mo.); by U. of Pa.; at Sacred Heart Hosp.; 3 hrs. AAGP credit. Contact Robert F. Brennan, M.D., Sacred Heart Hosp., Allentown 18102.

March 10, 1970; Chester

I/AMA—**Clinical Implications of New Discovered Hormonal Agents** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 6, 1970; Philadelphia

I/AMA—**Evaluation and Treatment of Hypertensive Emergencies** (Program of Continuing Medical Education—1st Mon., 8 mos.); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 15, 1970; Reading

I/AMA—**Marital and Sexual Counseling for the Internist** (Continuing Education Program—3rd Wed., 8 mos.); by Hahnemann; at Community General Hosp. Contact Paul K. Stolz, M.D., Dir., Cont. Ed., Community Gen. Hosp., 135 N. 6th St., Reading 19601.

May 4, 1970; Philadelphia

I/AMA—**Extra Cranial Vascular Occlusions** (Program of Continuing Medical Education); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut So., Philadelphia 19107.

MENTAL RETARDATION

April 13-17, 1970; Elwyn

C—**Fourth Annual Symposium on Mental Retardation;** at Elwyn Institute; 7 hrs. each day; $25 fee. Contact Gerald R. Clark, M.D., President, Elwyn Institute, 111 Elwyn Rd., Elwyn 19063.

METABOLISM

December 30, 1969; Chester

I/AMA—**The Problem of Hyponatremia** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Penn State and Jefferson; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 6, 1970; Chester

I/AMA—**Aldosterone** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

NEUROLOGY

April 8, 1970; Philadelphia

C/AMA—**Teaching Day in Neurology;** at Albert Einstein Medical Center; 6 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 19141.

OBSTETRICS & GYNECOLOGY

December 2, 1969; Chester

I/AMA—**The Pill—More Than The Answer to a Maiden's Prayer?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 5-6, 1969; Philadelphia

C/AMA—**Social Problems in Obstetrics and Gynecology;** at Jefferson; 10 hrs. AAGP credit applied for; $40 fee. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 15, 1970; Wilkes-Barre General Hospital

I/AMA—**The Pill—More Than the Answer to a Maiden's Prayer?** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 11, 1970; Philadelphia

C/AMA—**Contraception and Management of the Infertile Couple;** at Albert Einstein Medical Center; 5 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 19141.

April 30, 1970; York Hospital

I/AMA—**Pathophysiology of Fallopian Tube Function** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

OPHTHALMOLOGY

April 15-17, 1970; Pittsburgh

C/S—**Ophthalmic Micro Surgery;** by Pitt; at Eye and Ear Hospital; 8 hrs. each day; $350 fee; Maximum registration—12. Contact Kenneth T. Richardson, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

April 20-22, 1970; Pittsburgh

C/S—**The Glaucomas;** by Pitt; at Eye and Ear Hospital; 8 hrs. each day; $150 fee; Maximum registration—20. Contact Kenneth T. Richardson, M.D., Eye and Ear Hospital, 230 Lothrop St., Pittsburgh 15213.

August 3-7, 1970; Pittsburgh

C/S—**The Management of Retinal Detachment;** by Pitt; at Eye & Ear Hosp.; 8 hrs. ea. day; $250 fee; max. regis.: 12. Contact Wm. G. Everett, M.D., Eye and Ear Hosp., 230 Lothrop Street, Pittsburgh 15213.

ORTHOPAEDICS

March 19, 1970; York Hospital

I/AMA—**Concepts of Bone Healing** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PEDIATRICS

December 11, 1969; York Hospital

I/AMA—**Selected Aspects of Neonatology** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

December 18, 1969; York Hospital

I/AMA—**The Delivery of Care to Pediatric Patients** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

December 18, 1969; Williamsport Hospital

I/AMA—**Urologic Problems in Children** (Postgraduate Seminars held 3rd Thurs. ea. month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 29, 1970; York Hospital

I/AMA—**Present Concepts of Pediatric Immunology** (Program of Continuing Medical Education Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

February 18, 1970; Scranton

I/AMA—**Pediatric Surgery** (Program of Continuing Medical Education—3rd Wed. ea. mo., 8 mos.); by Jefferson and Penn State; at Mercy Hosp.; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 2, 1970; Philadelphia

I/AMA—**Pediatric Office Emergencies** (Program of Continuing Medical Education—1st Mon., 8 mos.); by Jefferson and Penn State; at Methodist Hosp.; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 12, 1970; York Hospital

I/AMA—**What's New in Infectious Diseases in Children** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 31, 1970; Johnstown

I/AMA—**Neonatal Respiratory Syndromes** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 12-15, 1970; Philadelphia

C—**19th Annual Pediatric Postgraduate Seminar;** at St. Christopher's Hospital for Children; 6 hrs. each day; $100 fee. Contact John B. Bartram, M.D., Director, Division of Service to Handicapped, St. Christopher's Hospital, 2600 N. Lawrence St., Philadelphia 19133.

PHYSIOLOGY

April 2, 1970; York Hospital

I/AMA—**Physiology of Renal Function, Revisited** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Associate Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

April 9, 1970; York Hospital

I/AMA—**The Physiology of Contractility and Cardiac Failure** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 9-11, 1970; Philadelphia

C/AMA—**Current Concepts in Physiology of the Gastrointestinal, Endocrine and Respiratory Systems;** by American College of Physiology and American Physiological Society; at Holiday Inn; $60 fee—ACP members ($100, nonmembers). Contact Daniel H. Simmons, M.D., Director, ACP, 4200 Pine Street, Philadelphia 19104.

April 23, 1970; York Hospital

I/AMA—**The Physiology of Acidosis** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

PSYCHIATRY

Fourth Friday each month, September, 1969—June, 1970; Butler

I—**Physician-Community Psychiatrist Seminar;** by Mental Health Guidance Clinic of Butler Co.; at YWCA; Hour for hour AAGP credit. Contact Robert L. Eisler, M.D., Mental Health Guidance Clinic. 128 S. Main St., Butler 16001.

January 1, 1970 to February 11, 1970 (Each Wednesday); Philadelphia

I—**Depression and Suicide;** at Institute of Pa. Hosp., 18 hrs. AAGP credit. $25 fee. Contact Sydney E. Pulver, M.D., Program Director, Institute of Pa. Hosp., 111 N. 49th St., Philadelphia 19139.

January 14—March 18, 1970; Philadelphia

I/AMA—**Clinical Seminars in Medical Psychiatry (Advanced);** at Hahnemann—Each Wednesday, 10 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

February 18—May 13, 1970; Philadelphia

I—**Advanced Applied Office Psychiatry;** at the Institute of Pennsylvania Hospital—Each Wednesday, 12 weeks; 48 hrs. AAGP credit; $50 fee. Contact Sydney E. Pulver, M.D., The Institute, 111 N. 49th St., Philadelphia 19139.

February 19, 1970; Pottsville

I/AMA—**Differential Diagnostic Considerations of Psychosomatic Disorders** (Continuing Education Program — 3rd Wed., 8 mos.); by Hahnemann; at Good Samaritan Hosp. Contact Norman M. Wall, M.D., Med. Dir., Good Samaritan Hosp., E. Norwegian & Tremont Sts., Pottsville 17901.

February 24, 1970; Johnstown

I/AMA—**Psychotherapeutic Drugs** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St. Philadelphia 19107.

March 5, 1970; York Hospital

I/AMA—**Pathophysiology of Schizophrenia** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

March 19, 1970; Wilkes-Barre General Hospital

I/AMA—**Battle of the Sexes—Is Marriage Worth Saving?** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hours AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

April 1—June 3, 1970; Philadelphia

I/AMA—**Clinical Seminars in Medical Psychiatry (Advanced);** at Hahnemann—Each Wednesday, 10 weeks; AAGP credit applied for. Contact Paul J. Fink, M.D., Hahnemann, 230 N. Broad St., Philadelphia 19102.

RADIOLOGY AND RADIOISOTOPES

May 5, 1970; Chester

I/AMA—**The Use of Isotopes in Medicine** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

May 12, 1970; Chester

I/AMA—**Heavy Dose Irradiation—When Does it Palliate?** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

May 26, 1970; Johnstown

I/AMA—**Newer Diagnostic Aspects in Radiology** (Program of Continuing Medical Education—Last Tuesday, 7 months); at Conemaugh Valley Memorial Hospital; by Jefferson and Penn State; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

SURGERY

January 15, 1970; York Hospital

I/AMA—**Present Concepts of Surgical Ulcer Treatment** (Program of Continuing Medical Education—Each Thursday, 30 weeks); by Jefferson and Penn State; 3 hrs. AAGP credit; $40 fee for 30 weeks ($8 each). Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

February 18—March 25, 1970; Philadelphia

I/AMA—**Office Surgery;** Each Tuesday, 6 weeks; at Albert Einstein Medical Center; 18 hrs. AAGP credit; $75 fee. Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Rds., Philadelphia 19141.

UROLOGY

January 13, 1970; Chester

I/AMA—**Home Dialysis** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center; 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut St., Philadelphia 19107.

January 20, 1970; Chester

I/AMA—**The Kidney, Bones and Stones** (Program of Continuing Medical Education—Tuesday afternoon, 38 weeks); by Jefferson and Penn State; at Crozer-Chester Medical Center, 2 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson 1025 Walnut St., Philadelphia 19107.

March 18, 1970; Philadelphia

C/AMA—**Developments in Kidney Disease;** at Albert Einstein Medical Center; 6 hrs. AAGP credit; $25 fee (includes lunch). Contact Solomon Mintz, M.D., Ed. Chmn., Albert Einstein Medical Center, York & Tabor Roads, Philadelphia 19141.

April 16, 1970; Wilkes-Barre General Hospital

I/AMA—**Surgical Aspects of Inflammatory Diseases of the Bowel** (Program of Continuing Medical Education—One Thursday each month); by Jefferson and Penn State; 3 hrs. AAGP credit. Contact John H. Killough, Ph.D., M.D., Assoc. Dean, Jefferson, 1025 Walnut Street, Philadelphia 19107.

○ Indicates membership in the Pennsylvania Medical Society at time of death.

○ **Andrew R. Chancellor,** Pittsburgh; University of Pittsburgh School of Medicine, 1914; age 79; died September 7, 1969. He received the PMS Fifty-Year Award in 1964. He is survived by his wife, a son and two daughters.

○ **William I. Gash,** Philadelphia; University of Pennsylvania School of Medicine, 1923; age 70; died September 11, 1969. He was a veteran of World War I and had served as vice-president of the Philadelphia County Medical Society. Surviving are his wife, Ruth, two sons, one of whom is Robert P. Gash, M.D., two sisters and two brothers.

○ **Orville F. George,** South Fork; Hahnemann Medical College, 1921; age 76; died August 23, 1969. He had served as chief of the medical staff at Lee Hospital, Johnstown, and as school physician for the Forest Hills School District. He is survived by his wife, a daughter and a son, John O. George, M.D.

○ **John Patrick Gibbons,** Wilkes-Barre; Georgetown University School of Medicine, 1938; age 62; died September 1, 1969. Dr. Gibbons had served as Luzerne County Coroner for the past six years. He served in the Navy Medical Corps during World War II. Surviving are his wife and a son.

○ **Florence M. Kline,** Duarte, Calif.; Woman's Medical College of Pennsylvania, 1904; age 87; died August 28, 1969. She retired from active practice in 1959 and moved to California from West Deer Township, after more than fifty years of service in and around the Pittsburgh area. She is survived by a brother.

○ **Theodore Lidle,** Havertown; University of Pennsylvania School of Medicine, 1929; age 65; died August 30, 1969. Surviving are his wife, three daughters, one of whom is Faith Skattum, M.D., and a brother.

○ **Arthur C. McKinley,** Brookville; University of Pittsburgh School of Medicine, 1908; age 91; died August 14, 1969. He spent close to sixty years in the practice of medicine in Clarion and Jefferson Counties. He received the PMS Fifty-Year Award in 1958, and in 1967 was named "Brookville Man of the Year" by the Chamber of Commerce. Four sons, all of whom survive him, followed their father's footsteps in the medical profession, practicing in and around Brookville. They are Drs. A. Random, Oscar V., Wayne S., and William Mark McKinley. Also surviving are three daughters and two sisters.

○ **Norman H. Miller, Jr.,** Pittsburgh; University of Pittsburgh School of Medicine, 1953; age 46; died August 26, 1969. He served as an Air Force physician during World War II: Survivors include his mother and a brother.

○ **Harry W. Millikin,** Sarasota, Fla.; University of Pennsylvania School of Medicine, 1914; age 80; died September 2, 1969. He had served as a physician in Sharon for forty-two years prior to his retirement in 1957. He is survived by his wife.

○ **John McK. Mitchell,** Bryn Mawr; Yale University School of Medicine, 1924; age 74; died September 18, 1969. The pediatrician and educator had served as dean of the University of Pennsylvania School of Medicine from 1948 to 1962. He then served as director of medical education for Bryn Mawr Hospital until his retirement in 1966. He received many awards, including the Abraham Jacobi Award of the AMA in 1964. He served in both World Wars. He is survived by his wife, a daughter, a son and three stepsons, including F. Taylor Mauck, M.D.

○ **Charles C. Moore, Jr., M.D.,** Oakmont; University of Pittsburgh School of Medicine, 1947; age 45; died September 10, 1969. He was a Fellow of the American College of Surgeons. Surviving are his wife, three sons, two daughters, his father, Charles C. Moore, Sr., M.D., and a sister.

○ **Meyer W. Rubenstein,** Pittsburgh; Jefferson Medical College, 1923; age 69; died September 7, 1969. He was clinical associate professor of dermatology at the University of Pittsburgh School of Medicine and was a member of the Allegheny County Dermatological Association. He is survived by his wife, a son, Mark M. Rubenstein, M.D., San Francisco, Calif., a daughter and a brother.

○ **Charles J. Stybr,** Pittsburgh; Jefferson Medical College, 1900; age 91; died August 29, 1969. He is survived by his wife and daughter.

○ **William C. Taft,** Carlisle; Jefferson Medical College, 1940; age 54; died September 11, 1969. He served as a medical officer in the Army Air Force during World War II. He is survived by two daughters and a sister.

○ **Leo A. Wajert,** Pittsburgh; Creighton University Medical School, Omaha, Neb., 1935; age 64; died September 3, 1969. He practiced on the southside of Pittsburgh for more than thirty years. He is survived by his wife and a son.

○ **Theodore Wollak,** Scottdale; University of Maryland Medical School, Baltimore, Md., 1927; age 65; died September 15, 1969. He is survived by his wife, a daughter, two sisters, and a brother, Charles E. Wollak, M.D.

Samuel Chartock, Philadelphia; University of Pennsylvania School of Medicine, 1917; age 73; died September 8, 1969. He is survived by his wife, two daughters, a son, two brothers and a sister.

Robert T. Gildea, Tupper Lake, N. Y.; Hahnemann Medical College, 1948; age 47; died September 15, 1969. In 1966 he served as a Volunteer Physician in Vietnam under the AMA program. He was an associate member of the American Psychiatric Association. He is survived by his wife, four sons, one daughter and two bothers, one of whom is James E. Gildea, M.D., Chicago, Ill.

Morris Segal, Philadelphia; Jefferson Medical College, 1917; age 74; died August 24, 1969. In 1967 he was awarded the PMS Fifty-Year Award. He served in France and Germany during World War I. Surviving are his wife, a son and two sisters.

meetings

DECEMBER

Arthritis Foundation, Allied Health Professions, December 4, 1969; American Rheumatism Association Interim Scientic Session, December 5-6, 1969, Pioneer Hotel, Tucson, Ariz.

Annual Meeting, American Academy of Psychoanalysis, December 5-7, 1969, New York City.

Twenty-eighth Annual Meeting, American Academy of Dermatology, December 6-11, 1969, Americana Hotel, Bal Harbour, Fla.

Annual Meeting, American Society of Hematology, December 7-9, 1969, Cleveland, Ohio.

Annual Meeting, American Public Welfare Association, December 10-13, 1969, Dallas, Tex.

Annual Meeting, American Psychoanalytic Association, December 12-14, 1969, New York City.

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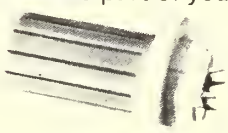

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Physician in General Medicine wanted: Active 200-bed GM&S hospital. Liberal vacation, sick leave, health benefits and retirement plan. Board certified or qualified preferred. GP with good background in internal medicine considered. U. S. citizenship preferred and license any state required. Equal opportunity employer. Contact Hospital Director, Veterans Administration Hospital, Altoona, Pa. 16603.

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in my opinion

Changing Patterns in the Doctor-Nurse Relationship

Organized nursing existed in ancient times, chiefly in leprosaria and pest houses. Care was entirely custodial and interestingly enough, the institutions were independent of physicians.

In 1856, shortly after the Crimean War, Florence Nightingale started the first school of nursing. It was not affiliated with a hospital, and it was not until 1880 that hospital schools of nursing were established. From that time, the number of nurses increased rapidly, and now in the United States there are over 582,000 professional nurses, of whom 67 per cent work in hospitals and related institutions.

From the time of the first association of nurses and doctors, a fixed pattern was established. The doctor initiated treatment and the nurses carried out the orders. The duties of the nurses were carefully limited, and in general there was little opportunity for independent activity. Even as recently as twenty years ago, the nurses' duties in the hospital were almost exclusively patient care—baths, enemas, temperature recordings, changing of linens, and to a modest extent dispensing of drugs and keeping records. More recently however, with ever increasing modalities of diagnosis and treatment, plus the critical shortage of physicians, many of the physician's tasks have been transferred by default to the nurse. Formerly the nurse was only permitted to inject specified drugs under the skin. Now at the Massachusetts General Hospital, a group of specially trained nurses give all intravenous therapy including drugs, fluids and blood. More important, they perform these tasks with more skill and efficiency than was previously demonstrated by the average physician, and it is anticipated that in the future nurses or other super technicians will do spinal taps, paracenteses, thoracenteses and minor surgery. Even now in certain rural areas public health nurses make home visits, evaluate patients, treat minor illnesses, and refer patients requiring definitive medical care to appropriate physicians. These nurses accept responsibility very close to that of the general practitioner. They act as the doctor's emissary, and they perform a creditable and necessary service.

The hospital nurses' primary role has now shifted from patient care to administration. She supervises the ancillary nursing staff, administers drugs, keeps extensive hospital and patient records, visits with patients, deals with distraught families and keeps the physician informed of changes in the patient's condition. In this sense the nurse has become less a nurse in the traditional sense, and more the physician's assistant.

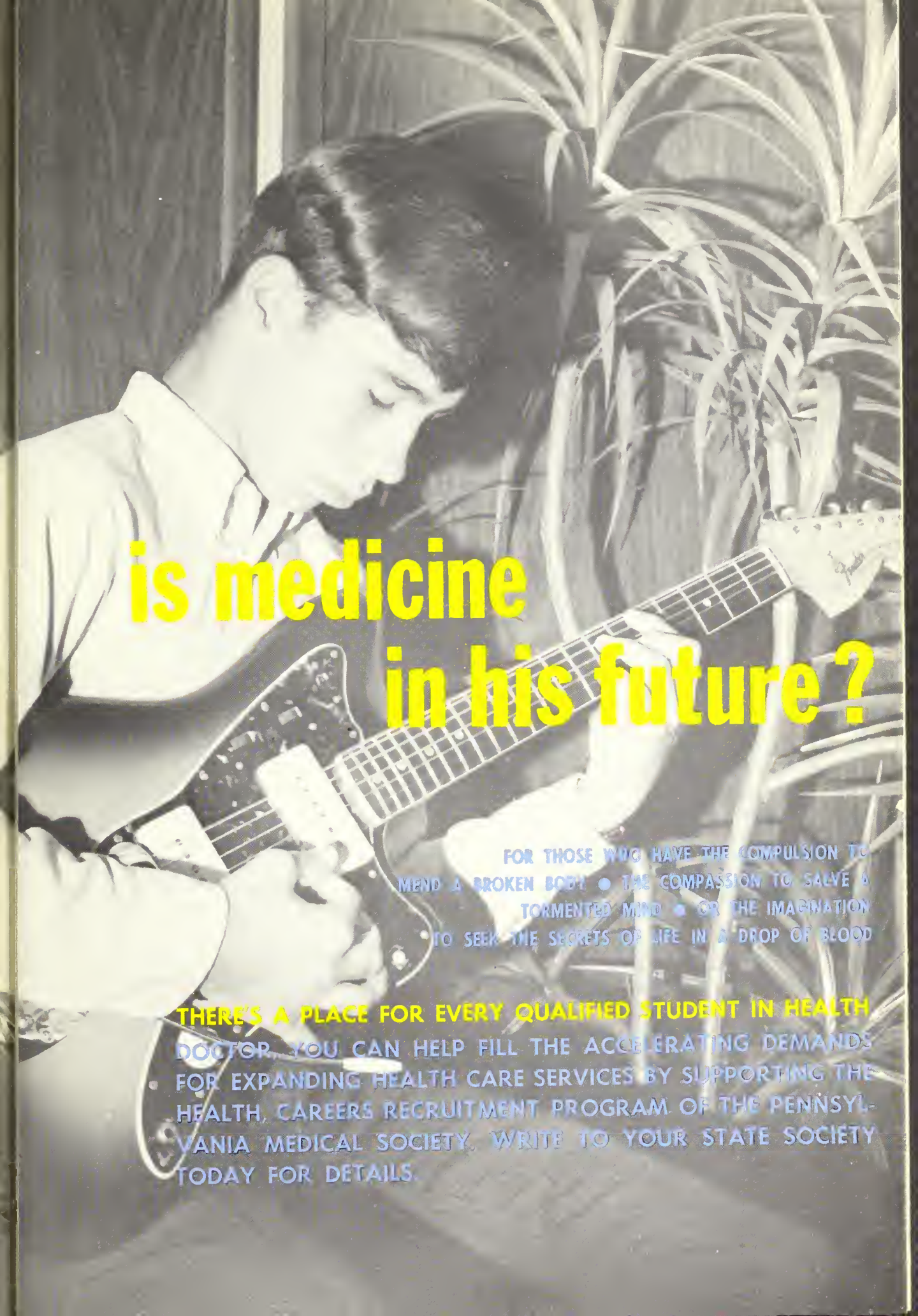
According to a recent survey only one-third of the total hours of nursing care in hospitals is provided by professional nurses; the remainder by licensed practical nurses, orderlies and nurses aides. Although physicians still desire the personal care of patients by registered nurses, they hardly expect it under prevailing circumstances.

The new role of the nurse may require some specialized training not included in the present curriculum. But even now much is being accomplished by "on the job training." The nurse accompanies the physician on his rounds where she is informed of diagnoses and the rationale of therapy. The good registered nurse on the floor is becoming increasingly knowledgeable in pharmacology, including average doses of drugs and particularly in allergic and toxic drugs reactions. This expertise is necessary, for she sees the patient innumerable times during the day, contrasted with the few minutes spent by the physician, and she is able to recognize subtle changes in the patient and to report these changes to the physician.

As proof, the following conversation recently was reported at one of our hospitals. "Doctor, this patient has been on .25 mgs of digoxin daily for fourteen days. His pulse is forty with coupling of beats and he is nauseated. Do you wish to discontinue the medication?" This is a good example of changing patterns.

In a recently published book, *Sickness and Society*, the authors, Raymond S. Duff, M.D. and August B. Hollingshead, Ph.D., present an expert in-depth survey of a large, unnamed American hospital. The following quotation from the book sums up the new attitude: "It is advisable for the attending physicians to sit down with the floor nurse and discuss the patients. He can learn much and quickly."

H. J. Levin, M.D.
Washington County Medical Bulletin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